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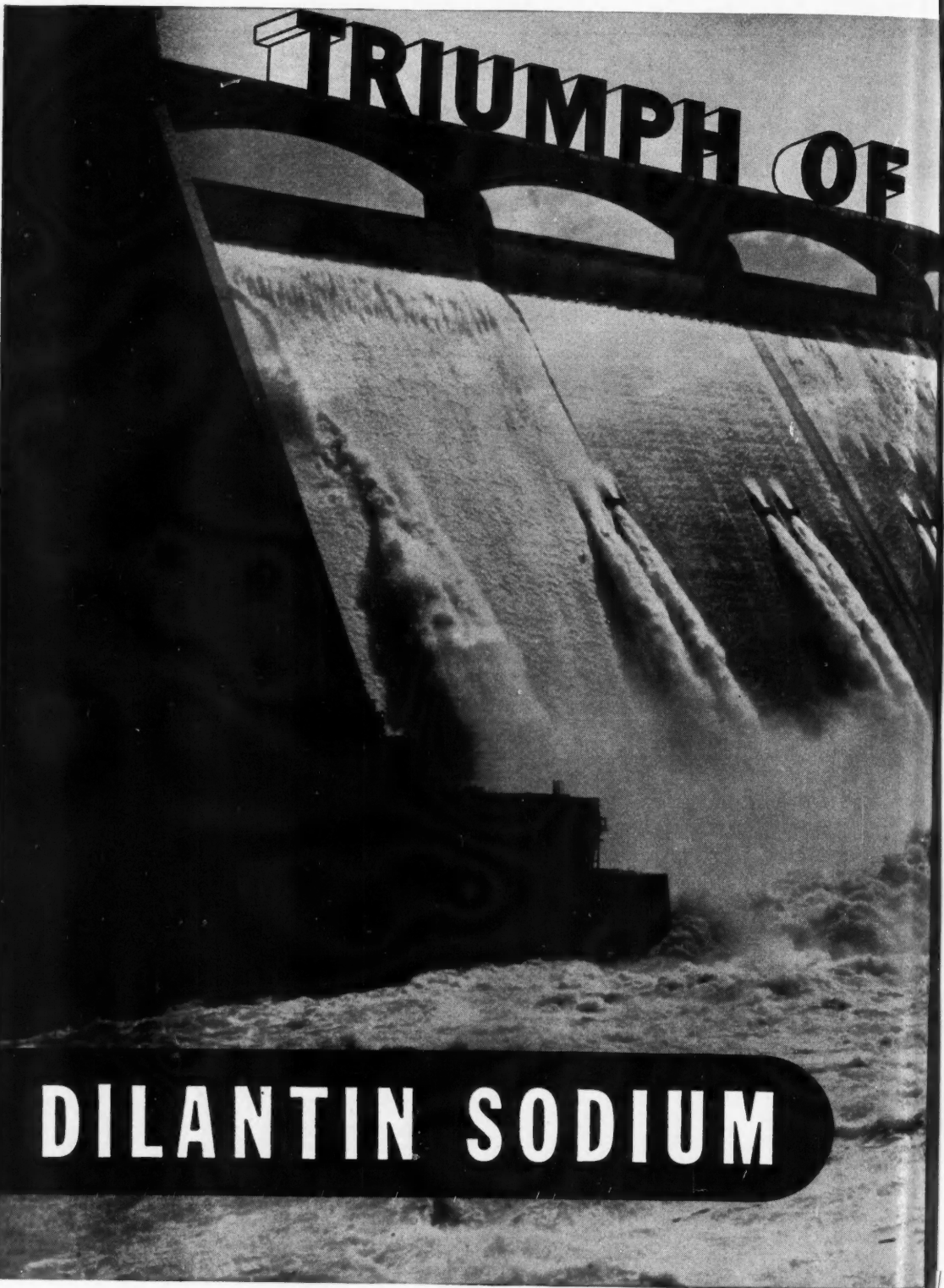
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EDITOR . . . . . GEORGE H. KRESS, M. D.

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Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

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**Leaflet Regarding Rules of Publication.**—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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## EDITORIALS

### HIGH COSTS OF SERIOUS ILLNESS OR INJURY—ARE THEY NOT, ABOVE ALL ELSE THE HOSPITALIZATION EXPENSES?

**Some Premises and Conclusions Regarding Psychologic and Other Reactions to Hospitalization Costs.**—On some things, today, referring to costs of unforeseen illnesses and injuries, lay citizens and physicians are or should be agreed. Included among such factors may be mentioned:

(a) The expense of care for unpredictable illness often brings financial impoverishment to many families belonging to middle class or lower income groups;

(b) Present-day expenses are in very good part the result of existing systems of medical practice; in which, in order to provide a better quality of medical care, sick and injured persons are promptly sent to hospitals for treatment instead of being served in their homes, as in former years.

(So much have Americans changed in this respect, that even childbirth is now construed to be an event that should take place in a hospital, rather than in a home environment.)

(c) Physicians today, in metropolitan, and also in large and small cities and communities, carry on their major work in and under hospital conditions. Citizens have accepted this change, and rarely object when it is advised that they need hospital care for their illnesses or injuries, and, those who do, hesitate rather because of hospital expenses, than from other reasons.

(d) Even though citizens be willing to be sent to hospitals, that fact does not lessen their unhappiness when the calamitous hospital bills or reckonings for hospital services rendered, are submitted to them for payment.

(e) As a consequence, it is not surprising that thousands of citizens have come to the conclusion that something is radically wrong in medical practice, making them willing to lend kindly ears to proposals whereby the unforeseen and heavy hospital expenses, so often incident to medical care, may be minimized or entirely done away with.

Thus it happens that socialized and state medicine secure disciples and advocates.

And it is just here that specious and other propagandists for idealistic, theoretical or leftist changes,—no matter what may be their motivating reasons—are able to become a real part of the problem, since they lay the foundation for plans whereby state (governmental) medicine, or so-

called socialized medicine, would enter and supplant medical practice as it has been evolved and carried on in the United States.

\* \* \*

**Unhappiness Results from High but Natural and Unpreventable Hospitalization Costs.**—

If what has been above stated be true, it is logical to assume that citizens are not unhappy with the quality of medical care given in hospitals: but rather, are much dissatisfied with the expenses resulting from such service.

Families of physicians are no exception to this reaction, because medical men have no more relish for hospital expenses than their lay brethren; even though they can better appreciate than lay persons, why hospital expenses are what they are, and how little possibility there is of bringing maintenance costs of such institutions to a lower level—that is, to a level so moderate, that expense of hospital care would approximate those of home care, with members of the family or practical nurses giving care to the patient.

\* \* \*

**Hospital Costs Are Analogous to Costs in First Class Hotels, plus Additional Costs for Special and Extra Equipment and Personnel Made Available.**—What has been above stated is not intended to insinuate in relation to services rendered, that hospital expenses are excessive or extortionate. On the contrary, it is believed that hospital management in America has made a splendid record for efficiency. The wonder is, when all things are considered, not that the costs of hospitalization are as high as they are, but rather, that it is possible in most hospitals, to do as much as is done, for the money that is received in payment from patients.

It is unfortunate that so many citizens seem to think, because they are unfortunate enough to be ill, even though they may have needed and wanted hospitalization care, that the hospitals should charge little or nothing for the services they have rendered! (We see here the relation to the impression held for many years by some persons, that a physician is a servant of the people, to be available day or night, seven days in the week, even when there is no honest endeavor or even intention, to pay for services that may have been rendered.)

Very few hospitals have endowment or other funds that make it possible for them to accept patients belonging to different income classes, without asking return compensation.

Hospitals have arisen in all portions of the United States, in response to modern-day needs and trends. It must be remembered, however, as already stated, that hospitals in one sense, are only hotels whose clients are sick and injured citizens.

All the expenses incident to hotels apply therefore in good part to hospitals, plus many more that could be mentioned, incident to specialized equipment and personnel needed for the proper care of individuals who are more or less incapacitated by illness or injury.

**The Solution of the Problem of High but Necessary Hospital Costs Is Found in Prepayment Voluntary Insurance Coverage.**—

Having established the fact that modern-day medical care comprehends inclusion of hospital treatment and that such hospitalization is expensive—so much so that its utilization can and at times does bankrupt family groups, the question arises:—Is there no method whereby this unforeseen but necessary expense can be covered, so that its untoward and deplorable financial consequences to many families may be ameliorated or done away with?

Fortunately, here the answer can be in the affirmative.

Yes, through the application of the *prepayment insurance principle*—if a sufficient number of citizens align themselves in the mass effort—it is possible for citizens—inclusive of even the low income groups—at comparatively small cost, to protect themselves against the hazards of unforeseen hospital costs—just as they in similar manner and for like reason, protect themselves and their homes against fire loss, their automobiles from accident expenses, and so on.

That such hospital coverage is not an idle dream, but a realization readily accepted by the public, is amply shown in the phenomenal growth in the last few years of the Blue Cross Hospitalization plans that are now operative in almost all states of the Union.

Think of it—starting about the year 1937, in a small mutual school teachers' experiment at Dallas, Texas, this movement has now grown until today, more than 18 million citizens of the United States carry Blue Cross hospitalization protection!

(For recent articles in CALIFORNIA AND WESTERN MEDICINE, dealing with Hospital and Blue Cross development, see in following issues: July, 1945, p. 38 and 45; August, 1945, pp. 88 and 92; September, 1945, pp. 143 and 144.)

In California, three Blue Cross Hospitalization groups are successfully carrying on their respective work. The Association of California Hospitals has plans under way to combine their efforts for even greater results.\*

\* \* \*

**Acceptance of Hospitalization Coverage Is the Foundation and Forestructure of Medical Service Coverage.**—

A scanning or perusal of those references, with reflection on the significance of the figures presented, and the almost startling nature of pre-payment hospitalization growth should convince skeptical readers that hundreds of thousands of American citizens have accepted hospitalization insurance coverage, just as in past years, they have turned to protection against fire, automobile and other like hazards, in which mass union and cooperation was necessary in order to bring into play, protection of the person who may suffer an individual loss.

\* For other comment, see in current issue of CALIFORNIA AND WESTERN MEDICINE, on page 181 (Minutes, Item 2).

The way to best combat "compulsory sickness insurance" (compulsory governmental and state medicine insurance) is to prove that *voluntary hospitalization and medical coverage* is not only acceptable, but preferred and used by the majority of citizens. That objective can be attained if physicians everywhere will give wholehearted support to non-profit hospitalization and medical coverage plans exemplified by Blue Cross and California Physicians' Service.

#### COUNTY MEDICAL ASSOCIATION BULLETINS OF CALIFORNIA

**California Medical Association Is Proud of Bulletins of Its County Medical Societies.**—During the last several years the larger component county units of the California Medical Association, and in particular, Los Angeles, San Francisco, Alameda, Santa Clara and San Diego, have been printing *Bulletins*; in fact, on occasions, of such size as to be classed as small medical journals.

In the August issue of CALIFORNIA AND WESTERN MEDICINE mention was made of the latest addition to this group of county publications; namely, *The Bulletin of the Alameda County Medical Association*.

If it were possible to permit every member of the California Medical Association to receive at least once each year a copy of the respective *Bulletins*, we are certain their perusal would be provocative of increased interest in organized medicine.

*The Bulletin of the Los Angeles County Medical Association* is the largest of the group and is the source of a very considerable annual income to that component county society.

Each of the *Bulletins* presents from month to month information of much importance to local members, and in addition, the editors of the respective publications are generous in their consideration of problems confronting organized and scientific medicine. The wholehearted service rendered by the Publication Committees of these *County Bulletins* is worthy of praise, and the Editorial Board of CALIFORNIA AND WESTERN MEDICINE esteems it a privilege to call the attention of members of the California Medical Association to the services that are so rendered.

Good wishes are extended to these publications and also to the editors of the mimeographed and other *Bulletins* supported by others of the component county medical units of the C.M.A. Good wishes to each and all of them.

#### AMERICAN MEDICAL ASSOCIATION MEMBERSHIP STATISTICS

**California Leads All States in Percentage of J.A.M.A. Subscriptions.**—In its issue of September 29, 1945, the *Journal of the American Medical Association*, commencing on page 360, prints items from the report of the A.M.A. Board of Trustees. In Table 1 on "Approximate Count of Fellows and Subscribers on the *Journal Mail-*

ing List January 1, 1945," statistics are given for the various states.

California is credited not only with 4,741 Fellows (Fellows of the A.M.A. are members of the state medical associations who subscribe in advance for the *J.A.M.A.*, and apply at the same time through a state medical association office for A.M.A. Fellowship), but also with 4,475 subscribers, making a grand total of 9,216 A.M.A. Fellows and *J.A.M.A.* subscribers for California. New York, of course, has a larger number, but Pennsylvania has a total of only 8,367; Illinois, 7,023; Ohio, 4,774.

Table 2 dealing with "Percentage of Physicians Receiving the *Journal of the A.M.A.*" based upon number of physicians credited with residence in California according to the 17th Edition of the *A.M.A. Directory*, gives California a total of 9,216 resident California physicians who receive the *J.A.M.A.*, and a total of 12,365 physicians credited with residence in California, thus making the approximate percentage of California physicians who receive the *J.A.M.A.*, 75 per cent.

This is the highest percentage recorded for any one of the states of the Union! The next highest percentage is credited to Utah with 72 per cent, followed by New York, with 65 per cent. Maryland with 64 per cent, then by Arizona and Nevada with 63 per cent, and Pennsylvania with 62 per cent. Massachusetts is given 53 per cent.

Not so bad for the "Wild and Woolly West"?

\* \* \*

**A.M.A. Library Report.**—Concerning the work of the A.M.A. Library, at 535 North Dearborn, Chicago, the following information is given.

#### A.M.A. Library

Requests for the loan of 10,836 periodicals were received and filled by the Library of the American Medical Association in 1944. The requests came from physicians in military service in this country and overseas and from civilian physicians in each of the forty-eight states. Chicago libraries also availed themselves of the service to a considerable extent, the American College of Surgeons having had the loan of 498 periodicals, the Medical Library of Northwestern University School of Medicine 172, the John Crerar Medical Library 338 and the University of Illinois School of Medicine 45. Periodicals and miscellaneous medical reprints were lent to 291 physicians serving with the armed forces.

About 2,000 package libraries were lent during the year. Approximately one-fourth of the requests for this service came from physicians in the various military services of the United States.

The subjects most frequently requested during the year were the Rh factor; penicillin; military medicine, including various phases of tropical medicine, aviation medicine, burns and malaria; blood pressure; sulfonamides; anesthesia, and blood transfusion.

Approximately 200 requests were received from physicians overseas, who stated that they were desperately in need of material on certain subjects. Miscellaneous reference questions numbering 4,500 were answered by letter and telephone.

1 1 1

**Why Not Similar Reports from California Libraries?**—It would be interesting if similar reports along analogous lines could be sent to the OFFICIAL JOURNAL of the California Medical Association by the Lane Library, of Stanford University, University of California Medical Library, and the Library of the Los Angeles County Medical Association.

The J.A.M.A. membership and subscription figures above given should be gratifying to members of the medical profession of California, since they indicate a special interest, not only in scientific, but in organized medicine.

It would be interesting to know to what extent the interest created among California physicians through the continued endeavors made in the California Legislature to promote compulsory sickness insurance plans may have played a part in the creation of the high percentages which are credited to California in regard to A.M.A. Fellowships and J.A.M.A. subscriptions.

## EDITORIAL COMMENT†

### HYBRID YEASTS

Demonstration that there is both sexual and asexual reproductive cycle in yeasts, suggested to earlier investigators the possibility of producing desirable new combinations of usable properties in industrial yeasts of hybridization.<sup>1</sup> For example, no natural yeast is capable of fermenting both lactose and maltose.<sup>2</sup> It was conceived that if a lactose-fermenter could be mated with a maltose-fermenter, the resulting hybrid would be of practical industrial interest.

The sexual cycle varies with different yeasts, and is usually more complex than sexual reproduction in higher plants. In 1918 Kruis and Satava<sup>3</sup> of Czechoslovakia showed that the ordinary vegetative cells of *Saccharomyces cerevisiae* are diploid in character, i.e., they have a double number of chromosomes. Under certain unfavorable conditions these diploid cells may segment into four haploid cells, each containing a single number of chromosomes. These ascospores may germinate to produce small round haploid cells, easily distinguishable from ordinary vegetative cells by gross colony structure.

Lindegren<sup>4</sup> of the Henry Shaw School of Botany, Washington University, St. Louis, Mo., subsequently found that these small haploid cells often unite to reform large diploid cells, provided the haplophase cells are of complementary "sex" or mating types. Two mating types were recognized by him. "Legitimate" reproduction takes place by the union of haplophase cells of opposite "sex." "Illegitimate" progeny are formed by "homosexual" union. The illegitimate diploids are usually smaller than legitimate diploids, though they are at times fully capable of growth and fermentation. They, however, usually do not sporulate, but often form fairly stable vegetative cultures, if grown under conditions that do not necessitate sporulation. In addition to these two "sexes" there are usually a number of "neuter" haploids which do not mate.

The first successful hybridization of different species of yeast was reported in 1935 by Winge and Lansten.<sup>5</sup> By means of a micromanipulator they placed a haploid ascospore from one strain of yeast in contact with an ascospore from another strain. When all conditions were favorable, "copulation" with exchange of nuclear material took place between the two ascospores, followed by their fusion to produce a diploid vegetative cell. A simpler hybridization technique was afterwards developed by Lindegren,<sup>2</sup> who mated different haplophase cultures, by placing a large drop of a heavy broth suspension of each culture together in a test tube. The mixtures were incubated for 24 hours at 23°C., and the desired hybrids isolated by plating methods.

By this technique Lindegren produced numerous relatively stable hybrid yeasts of promising industrial value. Medical interest, however, will presumably center on his more recent attempts to improve vitamin production by such hybridization methods.<sup>6</sup> He found, for example, that *S. carlsbergensis* is capable of synthesizing large quantities of biotin and pantothenic acid, but is unable to synthesize pyridoxine. *S. cerevisiae* synthesizes large quantities of pyridoxine, but does not synthesize biotin or pantothenic acid. He was able to bring about conjugation between these two species. The resulting hybrid was stable and synthesized all three vitamins in large quantities. In a similar way he found that *S. globosus* is capable of synthesizing pantothenic acid, but is incapable of producing thiamin. An unstable hybrid was made between this yeast with *S. cerevisiae*, and backcrossed with *S. cerevisiae*. The resulting second generation hybrid was stable and a good synthesizer of both thiamin and pantothenic acid.

Burkholder<sup>7</sup> of the Osborn Botanical Laboratory, Yale University, found that of 163 strains of commercial yeasts examined by him, nearly half were deficient synthesizers of three or more essential members of vitamin B complex. Nearly 90 per cent were deficient in the production of at least one essential member. The possibility of improving these deficiencies, therefore, is of wide practical interest.

P. O. Box 51.

W. H. MANWARING,  
Stanford University.

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

# PREVENTIVE AND PUBLIC HEALTH ASPECT OF RHEUMATIC FEVER IN CHILDREN\*

One of the first references to rheumatic heart disease was made in 1789, when Jenner reported to the Fleece Medical Society "Concerning diseases of the heart following acute rheumatism, illustrated by dissections." During the past twenty years, pathologists have demonstrated that rheumatic fever is a systemic disease, probably an infection, producing lesions throughout the body. The heart seems particularly susceptible, both to initial injury and later permanent scarring, and it is this fact which makes rheumatic fever a disease of exceptional importance in the field of public health.

As Swift says:

"Compare this disease with poliomyelitis—both killing only a small number in the initial attack—one crippling obviously and one insidiously—one conferring immunity and the other presenting recurring attacks with increased cardiac crippling. The economic importance of rheumatic fever is much greater than that of poliomyelitis, but the relative attention given them by the lay public, health authorities and vital statisticians is in striking contrast. Searching among reported deaths from heart disease gives only an inkling of the relative part played by rheumatic fever."

Rheumatic fever today is one of the foremost health problems of childhood. Between the ages of 5 and 9, deaths from it are outnumbered only by those of the four principal communicable diseases of childhood. Between 10 and 14, it is the leading cause of death; between 15 and 24 it is second only to tuberculosis.

There is confirmatory evidence of the presence of rheumatic heart disease following rheumatic fever with mild or unnoticed symptoms, and since the period of active rheumatic fever may be deceiving in its apparent mildness, great care should be given to accurate observations and diagnostic technique. How approach this problem? We do not know the specific etiologic agent. However, we do have many helpful facts: we know that there is a strong familial tendency towards the disease; 8 per cent to 10 per cent of the exposed persons in rheumatic families acquire the disease as against 3 per cent in control families. There is also possibly an hereditary factor. We know that the first attack occurs most commonly between four and fifteen years, and is rarely seen before two years or after twenty years. We know that the peak of attacks is in late winter and early spring and that damp, cold climates seem most unfavorable. We know that there is a close association with the streptococcus and that sore throat and respiratory infections are especially apt to incite trouble; also and probably most important of all from the public health and preventive standpoint are the factors of damp and crowding, malnutrition and fatigue, lack of sunshine, inferior medical care and inadequate clothing.

Rheumatic fever is a chronic and recurrent disease requiring long and expensive medical and institutional care. Any control program should

center around the "Rheumatic family" and should place emphasis upon case finding.

The program of prevention should cover many phases. We must strive to prevent the disease, to prevent heart damage once the disease has occurred and to prevent recurrences of the infection following the initial attack. To accomplish these things we must wage a campaign for educating the general public. We must support research to determine etiology, chemotherapy and immunotherapy. We must initiate programs for case findings, must furnish diagnostic centers for patients and provide hospital and convalescent care for the patients. Hospitals are best for the child in the acute stage, but for convalescence the rest home for convalescent rheumatics divided into small units and carefully guarded against upper respiratory infection is best. It is possible that for a period of several years anyway this disease is not cured but merely arrested, showing here a similarity to tuberculosis. It has been shown by Stroud, Martin, Swift and others that even in very intelligent homes and in those with higher incomes, it is difficult to keep a child on proper rest routine after he has begun to feel better and to prevent emotional problems among the family group. How much more difficult it is for those returning to unfavorable home conditions is shown by the fact that these have four times higher incidence of recurrence than those returning to good living conditions.

When the period of active infection is arrested, the task is just begun. Easily accessible facilities must be present for careful periodic check-ups of the patient and his family and for the prompt correction of medical, surgical or social pathology as it arises.

In 1939, the U. S. Department of Labor set aside certain Federal funds for the purpose of developing state programs for children with heart disease. These funds are available to states for extending and improving services, not for replacing services already being rendered by private and public agencies. The American Heart Association, the U. S. Public Health Service and the U. S. Bureau of the Census are coöperating in their respective fields to help conquer this disease, which from the viewpoint of age and distribution and its total mortality and morbidity ranks among the great unsolved problems of the era.

## RHEUMATIC FEVER IN SAN FRANCISCO

No significant statistical data are available on rheumatic heart disease in San Francisco. This disease was first made reportable in California in 1942 and 18 cases were reported in that year. In 1943, 30 cases were reported and in 1944 to date, 46 cases. These meager figures obviously do not give the true picture and their paucity is the best argument for a widely publicized and intensive rheumatic fever program.

In statistical and epidemiological studies of rheumatic heart disease in children, there appears to be marked geographic differences in the incidence of the disease. From the available information, no definite conclusions can be drawn as

to the disease being an infectious process, though the streptococcal group is generally associated with the laboratory findings, or secondary to the poverty triad of insufficient and incomplete diets, poor housing and overcrowding. Perhaps all of these are concerned in some manner.

The magnitude of the rheumatic heart as a disease problem is recognized by health officials. The statistical estimates of the death rate from heart disease in the group from 5 to 24 years is an indication of the prevalence of rheumatic heart disease. Sanatorium care for rheumatic heart disease is the most logical means of checking the severity of the infection and possible recurrences. It is also believed worthwhile to try the effect of change from cold, damp regions to warmer ones.

Specific home care for those discharged from sanatoriums is likewise deserving of special consideration. It is hoped that the medical and lay populations will come to recognize that sanatorium care is as important for rheumatic heart disease as it is for active tuberculosis.

101 Grove Street.

J. C. GEIGER,  
San Francisco.

#### Re: Medical Benevolence Funds

In the September issue of CALIFORNIA AND WESTERN MEDICINE editorial mention was made concerning the Benevolence Funds of the California Medical Association and Los Angeles County Medical Association.

The subject is one that should be of interest to many physicians. To reassure any C.M.A. members who may hold the belief that California is embarking into unknown seas, excerpts are here given from an article that appeared in the *Pennsylvania Medical Journal* (April, 1940, p. 1006):

#### *Medical Benevolence Fund of the Medical Society of the State of Pennsylvania*

The plan outlined below was inaugurated in Pennsylvania in 1905 by an allotment of 15c from the annual dues of each member of the Society. This allotment in the 35 years of the fund's history has averaged approximately 49c, and for the past 12 years has been \$1.00 annually. On Dec. 31, 1939, the fund approximated \$173,000 cash and bonds (par value).

In the wisdom of the Board of Trustees, only the contributions and the earnings from the fund are available for distribution. For many years the demand absorbed the earnings; therefore, the fund has grown and will continue to grow slowly under the allotment system unless those of our members who are financially able will contribute to it.

While it is not desirable that the benefits from this fund should at any time be looked upon as resembling the benefits operative under health, accident, or old-age insurance, the amount of money available for distribution should be sufficiently large to render real service to applicants (sick or aged) whose income is otherwise inadequate to provide the ordinary necessities of life.

The Woman's Auxiliaries of our state and county medical societies have contributed the magnificent sum of \$35,000 to the fund (total contributions \$38,500).

In the four years ending August, 1939, the fund averaged 33 beneficiaries, who received in the 48 months a total of \$37,532.

At present (in 1940) the fund has 35 beneficiaries who received a total of \$9,755 during the past 12 months, some in monthly payments, some quarterly, and some at irregular intervals according to the need.

The Committee on Benevolence, realizing the fund's inadequacy, herewith solicits subscriptions and legacies to be added to the principal. For your convenience blanks are attached. Contributions will be acknowledged through the columns of *The Pennsylvania Medical Journal*. Such contributions are recognized as proper for deduction in calculating one's annual income for tax purposes.

Excerpt from Article 9, Section 3, Constitution.—Each year, out of the funds of this Society, the trustees shall appropriate a sum not to exceed \$1.00 for each member, to be set aside by the Treasurer as a special fund to be known as the Medical Benevolence Fund. This fund shall be kept separate from other moneys, and may be invested by the Treasurer under the direction of the Board of Trustees, and shall be used only for the relief of pecuniary distress of sick or aged members, or the parents, widows, widowers, or children of deceased members.

Chapter 6, Section 6, By-Laws.—The Committee on Benevolence shall consist of the Secretary and 3 members to be selected annually by the trustees; at least one of whom shall be a trustee. This committee shall select its own chairman, secretary, and treasurer, and shall have absolute and confidential jurisdiction over the distribution of such part of the Medical Benevolence Fund as may be placed in its hands. No money shall be paid from its treasury except on warrant signed by the chairman and secretary of the committee, and an annual audit of its accounts shall be made by a committee of the trustees, the names of the beneficiaries being omitted. All beneficiaries shall be designated by number, and after each annual audit all communications tending to show the personality of the same shall be destroyed. This committee may solicit subscriptions, donations, and legacies to be added to the principal of the Medical Benevolence Fund. It may also receive subscriptions to be used for the relief of members in distress from the effects of any special catastrophe.

#### California State Industrial Accident Commission

Sacramento, Sept. 24.—Former Senator J. C. Garrison, who was appointed to the old State Industrial Accident Commission during the Olson administration, has raised a legal poser which has Governor Warren stumped.

Today, the Governor named five members to the new seven-member State Industrial Accident Commission.

The law creating the seven-member commission went into effect September 15. Garrison, whose term expired January 15, 1945, had not been replaced. Neither had he been reappointed. He now contends that since he was still functioning as a member of the commission when the new law became operative, he must be classified as a holdover member and continued on the new commission.

Alexander Watchman, San Francisco, also appointed during the last administration, holds a commission which does not expire until January 15, 1946, so he clearly continues in office.

The Governor has withheld action on the seventh member on the commission. He named Everett A. Corten, San Francisco, as chairman; Daniel Murphy, Jr., son of Sheriff Murphy of San Francisco; Ernest B. Webb, Long Beach, Ralph E. Mustoe and Anthony Racine of Los Angeles as commissioners. Paul Scharrenberg, who has served in the dual capacity of chairman of the commission and director of the industrial relations department, becomes director of the department solely, at salary of \$8,000 annually, instead of \$6,000 as formerly.

Corten, who has served as chief counsel for the commission, will receive \$7,500 annually, and his colleagues \$7,200.—*San Francisco Chronicle*, September 25.

America is the last abode of romance and other medieval phenomena.

—Eric Linklater, *Juan in America*.

This great spectacle of human happiness [America].

—Sydney Smith, *Essays: Waterton's Wanderings*.

## ORIGINAL ARTICLES

## Scientific and General

PSYCHOGENIC FACTORS IN OBSTETRICS  
AND GYNECOLOGY\*

ROY E. FALLAS, M. D.

Los Angeles

THIS symposium on Psychogenic Factors in Obstetrics and Gynecology, has been arranged in response to a specific need for information in the field of psycho-neuroses and psycho-therapy. The physician has always been aware that his medicine and surgery were often of secondary importance in affording relief to his patient. He knew that in a high percentage of his patients his intuitive understanding of their problems, their confidence in his wisdom and sympathy, and the freedom they enjoyed to disclose the hidden conflicts of their lives worked cures in some magical way.

Why has this unique patient-physician relationship been so effective as a therapeutic measure? Like so many remarkable phenomena surrounding us we have taken this particularly significant one for granted and failed to bring to bear upon it the analysis and study it deserved. The startling relief from symptoms experienced by patients after they have unburdened themselves to their confidant, the doctor, of secret unendurable conflicts, should have made us all suspect that a vital relationship of cause and effect existed in the conflict and the symptom. If we can, therefore, accept this relationship as valid, it would seem reasonable to take another step. If we can accept the theory that it is possible for a patient to suffer from conflicts unrecognized by him, of which he is completely unconscious because recognition would be too painful and disturbing we may then account for symptoms for which even the close physician-patient relationship may offer no relief.

## FREUD'S CONTRIBUTIONS

It was in this field of the unconscious conflict that Freud made his monumental contribution to human psychology. He pointed the way to a scientific instead of an intuitive understanding of the results obtained by the physician and developed a technique for the unearthing of the hidden conflict. But as so often happens in the history of science, his psychology and therapy met with profound suspicion and resistance, for he substituted science for magic; just as Holmes and Semmelweis substituted bacteriology for miasmas and faced the scorn of their colleagues.

There was a time in the history of medicine when, says Freud, "dissecting human corpses in order to discover the internal structure of the body was as much a matter for severe prohibition as practicing psycho-analysis, in order to discover the internal workings of the human mind, seems today to be a matter for condemnation."<sup>1</sup> This was written twenty-five years ago but still today in some medical circles the soundness of Freud's work is questioned. The explanation of this scepticism is perhaps that few of us are without some neurotic tendencies and that acceptance of Freud's psychology tends to make us aware of them, always a disagreeable experience. Add to this the disturbance of our profound belief in the infallibility of our chemical and physical science

and our hereditary religious and ethical concepts, and it is not too surprising that we turn with fierce resentment against this new concept which asks us to re-educate ourselves, take a new point of view and a re-orientation in medical philosophy. Oddly enough the most violent scoffer is most often the most poorly informed. He has probably never read Freud's introductory lectures, which, by the way, are examples almost without equal, of clear and logical writing capable of holding the interest of students to the end.

This lack of familiarity with a mental-therapeutic science considered by many to be as fundamental to medicine as physiology and anatomy, is however, being slowly corrected. Medical schools are incorporating psycho-analysis in their curricula and even popular magazines are bringing more and sounder information to the lay public. The war with all its trauma to minds as well as bodies has increased this interest.

These then are some of the reasons for this symposium. It is an attempt to offer some fundamental information and points of view for approach to the problems that we must all face with increasing frequency, so that we may more efficiently offer help, and perhaps cure to that large group of desperate people who wander from doctor to quack seeking a relief that can never be achieved by drug or surgery, but only by understanding.

1930 Wilshire Boulevard.

## REFERENCE

1. Sigmund Freud. A General Introduction to Psycho-analysis.

## PSYCHOGENIC FACTORS IN OBSTETRICS\*

FRANCES HOLMES, M. D.

Los Angeles

IT has become apparent that in diseases such as ulcers, asthma, and colitis, the "emotional factor" is very important, perhaps the entire etiology. Since pregnancy, labor, and the puerperium are considered "normal processes," the profound emotional changes which take place are too often overlooked or made light of. The obstetrician must deal with three situations:

1. The prolonged period of pregnancy.
2. The acute period of labor and delivery.
3. The indeterminate postpartum period.

The fact that this involves approximately one year of the patient's life is in itself significant for the development of psychological stresses. Obstetricians are becoming more aware of these factors in their patients. Since a patient may express one attitude and at the same time harbor an opposite one, we see conflicts arising. Many women consciously have no desire for children; others have unconscious aversions to pregnancy, but express conscious desires. In both cases the conflict results in a psychological and physiological reaction.

## A WOMAN'S ATTITUDE CONCERNING PREGNANCY

A woman's attitude toward pregnancy is based on early sex education, satisfactory sexual adjustment, and a desire for a child. If pregnancy occurs shortly after marriage or too soon after a previous pregnancy, in a family not financially secure, there naturally arises an antagonism towards the child and an unconscious rejection of it. The woman who does not want a child is thought to have rejected the feminine rôle. A truly normally adjusted woman does not reject pregnancy.

\* Chairman's Address. Given before the Section on Obstetrics and Gynecology, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945. One of five papers in a Symposium on Psychogenic Factors in Obstetrics and Gynecology.

\* Read before the Section on Obstetrics and Gynecology, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945. One of five papers in a Symposium on Psychogenic Factors in Obstetrics and Gynecology.  
Ed. Note.—Many references were given, but not being keyed in text, are not printed.

Then there are the women in whom there is a strong selfish desire for children because it is a means of getting support or inheritance or a method of binding the husband to her.

A tragic situation is observed in unmarried women who strongly desire children. Since they can accomplish this aim only by defiance of public opinion, there arises a pronounced state of frustration. This is believed to be one of the major psychological mal-adjustments in American women.

Many obstetricians do not regard psychological influences as a factor in sterility, although there is a growing opinion among psychiatrists that unconscious wishes may be of considerable importance. It is a well known fact that if you want a sterility patient to become pregnant, have her adopt a child!

#### EMOTIONAL ATTITUDES TOWARD PREGNANCY

Once pregnancy has taken place, certain emotional stresses come into play. These will vary according to whether the child is wanted by one or both parents, or is an unwished for event. Most parents attempt to reconcile themselves, but a conscious acceptance of the inevitable does not always indicate an ability to adjust to it. The obstetrician recognizes that unconscious rejection is often expressed by excessive vomiting. The readjustment to the growing tumor that the patient must make in her social and sexual life as well as to her increasing physical unattractiveness are all important facts to keep in mind.

Many pregnant women become conscious of their heart beat, their fatigue alarms them, they are more inclined to weep, are more sensitive to remarks or criticisms; they are more critical, more exacting, more demanding. They may use their "condition" as a means of demanding more attention and love from their husband, since they fear the loss of his love because of their loss of figure. In instances when the husband and relatives' indulgences are excessive, the wife's neurotic satisfactions may be increased and with them may go a rejection of her mature rôle and even of the pregnancy itself.

Anxieties may arise due to ignorance or misconception. "Old Wives Tales" and sadistic reports of older women regarding their experiences with pregnancy are not without their effect even on the most normal women. Hirst states that all pregnant women are anxious to a degree beyond that of a normal non-pregnant woman.

#### ELEMENT OF FEAR

The meaning of pregnancy to the mother varies but some generalities are noted. In no other state is fear such a dominant factor. This fear differs in intensity and manner of expression, depending upon the personality of the mother. Superstitions and poor sex education are largely responsible. Ignorance as to the mechanism of birth may be a factor.

Fears most frequently encountered are:

1. Fear of the child being deformed, feeble minded or marked. It is interesting to note that usually the first question asked by the mother after delivery is, "Is the baby all right?"
2. Fear of death to themselves or the child.
3. Fear of sexual intercourse!
  - (a) Fear of its effect upon the husband if denied.
  - (b) Fear of its effect upon the child if permitted.
4. Fear of childbirth; such as attendant pain, lacerations.
5. Fear of getting out of shape.
6. Fear of responsibility of bringing up a child.

#### FEAR ELEMENT: ITS TREATMENT

The treatment consists:

1. Recognition of these fears and the influence that they exert.
2. Encouragement of frank expression of them by the patient.

3. Attempt of the doctor to evaluate these fears in order that the patient may adjust her attitude towards them.

A most important factor in the emotional state is whether the child is wanted or not. An illegitimate pregnancy with its social, economic, and emotional complications will set up entirely different reactions from a very much desired pregnancy. Illegitimacy is not the only situation where pregnancy is undesired. A pregnancy which occurs in spite of contraceptives and persists after measures to produce abortion, is frequently associated with bitterness and resentment, and a sense of guilt, as well as fear that the child may have been harmed by these attempts and will therefore be abnormal.

Other causes of unwanted pregnancies are economic— inability to give the child what the parents desire for it; the number of children already in the family; discomforts of previous pregnancies; fear that the marital relations will be adversely affected. In an unhappy marriage a child is usually not wanted. If the husband reacts unfavorably towards the pregnancy, this will effect the wife's attitude. The physical and social limitations imposed by pregnancy may be the cause of resentment. Having a child to improve the relations of an unhappily married couple is not advisable and does not produce healthy attitudes. Most women who do not desire a pregnancy will resign themselves to it with fairly good grace. In some, the attitude of rejection may be so deeply rooted that the obstetrician must give his full attention to it. Rejection of the pregnancy may be expressed as pernicious vomiting, or as an inability to carry out doctors' orders.

Rejection by vomiting is usually seen in the educated, intelligent girl, practically never seen in the southern negro. Vomiting is worse in unwanted pregnancies. Neurotic individuals become increasingly so in states of pregnancy. The patient unconsciously would like to get rid of the child and because her earliest conception of pregnancy was that the baby was in the mother's stomach, she believes it possible to rid herself of it by vomiting. Later education fails to eradicate these childhood beliefs.

#### PROPHYLAXIS

Prophylaxis would be approached as follows:

1. Healthy emotional development of the child.
2. Adequate sex education especially as applied to marriage, pregnancy, and motherhood.
3. Eradication of the belief that morning sickness is an inevitable symptom of pregnancy.

#### PERNICIOUS VOMITING

Immediate Treatment of Pernicious Vomiting:

1. Isolate patient in quiet room.
2. Explain the vomiting as her emotional rejection of the pregnancy. Explain the mental mechanism previously described.

Hirst cites a case of pernicious vomiting in a 32-year-old primipara. When the vomiting first occurred, the patient's father had said to her, "You will have a bad time of it as your mother vomited the entire time she was carrying you." When her doctor explained that the vomiting was occurring only because of the suggestion from her father, and that she was now cured, she had no further attacks. Eleven months after delivery, she became pregnant again, greatly to her indignation, and vomiting became pernicious. Again Dr. Hirst saw her and felt that it was produced by a semi-conscious desire to end an unwanted pregnancy. She was told that the

vomiting would cease as soon as she made up her mind that she would have to face her problem, and go through with the pregnancy, that the vomiting would not be regarded as an excuse for terminating it. The following meal she retained, and no further difficulty was experienced.

Hirst feels that all pernicious vomiting is hysterical and curable by suggestion, that the physiological vomiting of the first weeks gives rise to the suggestion of continued vomiting which can be stopped by explanation and persuasion, without recourse to isolation, diet, drugs, which act only by suggestion. Hysterical vomiting in one pregnancy is likely to suggest a recurrence in all subsequent pregnancies.

#### PATIENT-PHYSICIAN RELATIONSHIP

An obstetrician must be aware of all the anxieties that may upset his patient and must encourage the patient to talk about them. He should truthfully explain the facts of pregnancy and delivery. It is, as a rule, unwise to show pictures which illustrate the process of child birth as this is often too realistic and will horrify rather than relieve the anxieties. It is not advisable to tell patients that they had a difficult labor or a hard delivery. This may cause the convalescent period to be prolonged and be responsible for a state of passive dependency that persists longer than is normal. The doctor too often deals with the problem by a pat on the back and a cheery word that everything will be all right. This does not allay fear. The patient must be taught to live with it. She can be convinced that this fear underlies her nervousness, sleeplessness, etc. She must be encouraged to discuss her fears. If she is told that fear is a natural accompaniment of pregnancy, she will have a minimum of symptoms.

It is most important that the doctor know the patient's personality and her "way of experiencing." It is common knowledge that the same event has different significance for different individuals. The event assumes whatever meaning the patient places on it herself. The patient's concept of herself in relation to the world must be noted:

Does she submit passively to the environment, being buffeted about by it, or does she value herself above everything else, considering the world as something to be dominated by her?

Will she consider her pregnancy as an encroachment of the world on herself, or will she experience it as an aggrandizement of her already extensive ego-valuation? Will she submit to it or rebel against it?

Consideration must be given to the way the patient experiences herself in relation to her body. Does she become alarmed at the occurrence of normal phenomena or does she minimize events of possible pathological significance? With this knowledge, the patient helps the doctor to evaluate her symptoms such as dizziness, heart burn, etc., that she will complain of.

#### PATIENT'S ATTITUDE TOWARDS LABOR

The patient's attitude towards labor must be considered. There is a wide variation in sensitivity to pain. With the months of discomfort preceding delivery, labor is not a dreaded ordeal, but rather a promise of release from a burden. Rarely is it such a traumatic experience that the mother develops hostilities towards her child, or feels that she can never be repaid for her suffering.

The effect of emotions on labor is to be considered. The nature of the contractions may be affected by unconscious emotional factors. The patient, during her antepartum period, should be conditioned to minimize the discomforts of labor.

#### POSTPARTUM PERIOD

Fortunately for most women, the nine months of pregnancy is a happy experience, but with the postpartum

period, a new set of trials begin. The child now becomes the center of attention, rather than the mother, who becomes the servant for the child. She finds that she now has a hard job. The acceptance of the maternal rôle is largely determined by her emotional maturity and stability. Her success is greatly determined by the husband's attitude to the new arrival in the family. It is in the postpartum period that the more serious emotional complications develop. The change from being a pregnant woman who received a great deal of attention from her entire family, to the state of being a mother where the attention and care is directed to the baby, and she is expected to resume her former status, plus the added responsibility of the child, certainly carries with it many emotional changes. The restriction of social activities, the problem of fitting a new member into the family without causing jealousy from the other children is often difficult.

#### PERSONALITY CHANGES

Symptomatology is often manifest in sexual matters such as antagonism towards husband, distaste for sexual relations, abnormal sexual behavior; or as amnesia of the birth, belief that the child is dead or is not her own, or as actual attempts to kill it.

The earliest symptoms of a beginning psychosis is that of personality change. Frequently it is observed as general discontent, increasing tension, excessive anxiety, insomnia, and irritableness.

The emotional instability which so often accompanies pregnancy must be recognized by the obstetrician and treated to prevent its further development into a more serious emotional state. The handling of such matters must be by the doctor and not by well meaning friends whose advice is tainted with superstitions, fantasies, and fears. The period of pregnancy is not an easy one emotionally as the patient is bombarded with advice and information, usually of a morbid nature concerning herself and her unborn child. Since every woman is temperamentally different, it follows that no two pregnant women can be handled in the same way. When nervous tensions are noted, obstetrician must take the time to talk over whatever problems are present. He must know when to ask leading questions, how to provide the release for tears that are just beneath the surface. When he makes light of her worries, she will keep them to herself and they can assume tremendous proportions. The prenatal build-up period must include the emotions as well as the physical—sympathy and understanding must be the doctor's attitude toward the patient, and frankness even to the point of offensiveness should be his attitude toward a family which is inclined to keep the patient agitated by a morbid atmosphere.

#### SUMMARY

In an obstetrical practice, one sees a cross section of life, birth, death, hope, eager anticipation, growth of a sense of responsibility, despair, tragedy, and comedy.

This is a plea to the doctor to try to understand what underlies the anxieties so often seen in pregnancy and to give wholesome mental food throughout pregnancy, labor, and the puerperium.

3780 Wilshire Boulevard.

America is a country of young men.

—Emerson, *Society and Solitude: Old Age*.

Some hae meat and canna eat,  
And some wad eat that want it;  
But we hae meat and we can eat,  
And sae the Lord be thankit.

—Robert Burns, *The Selkirk Grace*.

## PSYCHOGENIC FACTORS IN GYNECOLOGY\*

GEORGE E. JUDD, M.D.

Los Angeles

THE origin and derivation of the word hysteria, which means the wandering of the uterus, serves to impress us with the long recognized relationship between disorders of the genital tract and psychological disturbances.

### HISTORICAL

A review of the historical background goes back to Hippocrates and Galen whose writings and ideas were dominated by the feeling that diseased genital organs were the underlying cause of many manifestations of hysterical disturbances.

This idea of the adverse effect of genital pathology upon the psyche was embraced and carried along by medical men through most of the 19th century—and as late as 1893 it was taught that "It is preëminently diseases of the hystera, of the uterus and its adnexae, which lead to the most pronounced and most frequent symptoms of hysteria."<sup>1</sup>

In the late eighties anomalies of position, ulceration of the cervix and chronic metritis were considered the underlying pathology of hysteria.

There developed a reversal of this viewpoint at the turn of the century by epoch making works of Bleuler, Freud, Breuer and Janet.<sup>2</sup> They called attention to the psychic aspect of many functional disturbances and ailments. This was particularly applicable to internal medicine, although resistance to the idea by the leaders of gynecology was felt then and still is for that matter.

Kroenig in 1902<sup>3</sup> stressed the importance of functional nervous disorders in gynecological diagnosis and therapy. He recognized as purely psychogenic certain hyperesthesias of the genitalia. He emphasized the frequent occurrence of psychogenic pruritis vulvae and mentioned psychogenic sensation of prolapse without prolapse.

As a result of this new conception of symptom production many discussions in gynecological societies occurred, the consensus of opinion was that although many favored the psychogenesis of genital disorders the majority did not think that disturbances could be caused solely by psychic processes. They rationalized that the symptoms produced in the absence of pathology were due to changes in the central or peripheral nerves that were as yet not recognized.

Bossi and Schultz<sup>4</sup> as late as 1912 attempted to prove that diseases of the genital organs in the female were essential etiological factors in mental disturbance, even insanity and suicide.

Siemerling and Walthard, among others, were early leaders who recognized the fact that psychiatry had come into its own in gynecology and general medicine and not that gynecology had taken up an abode in psychiatry.

Walthard separated the cases with psychogenic disturbances and treated this group with psychotherapy—this consisted almost entirely of suggestion. By the time World War I came along many men observed and confirmed the fact that marked psychic traumata and chronic disturbed emotional states produced marked effects upon the menstrual function.

A. Mayer, Director of the University Women's Clinic of Tübingen<sup>5</sup> said that "many of our patients present gynecological symptoms without being sick gynecologically. Their illness is a psychic conflict sailing under

a gynecological flag, a fact that has not escaped the attention of the quacks."

Grafenberg, 1929,<sup>6</sup> says, "It has become more and more a matter of course for the gynecologist to take psychic factors into consideration in evaluating the symptoms of women."

### PURPOSE OF ARTICLE

This statement expresses briefly the purpose back of this paper; to more or less call attention to the problems of the personality and emotions that may be etiological factors in the symptom picture that is presented to us as gynecologists. Much criticism has been leveled at the specialist for focusing his attention upon his own particular anatomical field without knowing much of the remainder of the body, but even more the short period of observation allows no information about the background of the patient's personality. This knowledge of the patient, her development and family that was so well known by the general practitioner or the old "family doctor," in so many cases enabled him to treat with keen insight many symptom complexes in ways that flaunted the scientific knowledge of pharmacology and pathology.

We may readily ask them what symptoms could psychic factors prove to have etiological influence.

### DYSMENORRHEA

The first condition that comes to mind that is recognized today to have psychogenic factors in its production is dysmenorrhea. This common gynecological complaint has long been recognized as being influenced by the attitude of the patient towards the presence of the menstrual flow. J. Novak and Harnik<sup>6</sup> reported 247 cases of dysmenorrhea where psychic traumata was indicated as the inciting cause of the symptom—with the use of psychotherapy directed towards the recovery of the memory of the trauma and with reassurance as to the underlying cause, was followed by complete relief of 62 per cent, partial relief in 34 per cent—failure in 4 per cent.

Hypnotic control of dysmenorrhea was reported to be very successful by Margaret Brennan of the Menninger Clinic.<sup>7</sup>

The treatment of primary dysmenorrhea in modern text books of gynecology call attention to psychogenic factors of its production. They call attention to the fact that many times painful periods are found in emotionally high strung and often unstable girls and many of them call attention to the development of the pain some months or years after the initiation of the menstrual flow.

The relief of pain following a sympathetic explanation with reassurance by the gynecologist has proved to be a value and has established the fact that psychogenic factors are present in dysmenorrhea.

### FRIGIDITY

The next most common complaint coming to the gynecologist where it is clearly recognized that psychogenic factors exist in its etiological background is, frigidity. Robert P. Knight in the Bulletin of the Menninger Clinic<sup>8</sup> reports the fact that 75 per cent of women derive little or no pleasure from the sexual act. He feels that prejudice, revulsions, anxieties referable to menstruation, pregnancy, childbirth, intercourse, lactation, child training are pertinent factors in the sexual anesthesia. He says many of these feelings and attitudes stem from older women both in and out of the family.

The treatment of this condition, even though the gynecologist is often the "father confessor" to many of his patients, has been taken over by the psychiatrist, psychologist or psychoanalyst. The gynecologist is relegated usually to treating only those conditions in which anatomical factors may mechanically interfere.

\* Read before the Section on Obstetrics and Gynecology, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945. One of five papers in a Symposium on Psychogenic Factors in Obstetrics and Gynecology.

There is not much question of psychogenic factors in these two conditions—what about other symptoms. The triad of bleeding, pain and leucorrhea has been called the daily bread of the gynecologist.

#### AMENORRHEA

The question of bleeding brings up metro and menorrhagia as well as amenorrhea. To begin with amenorrhea is not infrequently the result of episodes of emotional stress. R. Schindler, 1927,<sup>9</sup> reported a number of war amenorrheas. This was found in well nourished, robust women. The condition often disappeared with the return of the husband on leave.

Kohnstamm and Forel<sup>12</sup> induced periods of amenorrhea up to several months with hypnosis.

The amenorrhea of pseudocyesis is too well known to require any additional proof that emotional states can cause the cessation of menstrual flow for several months.

#### METRO-MENORRHAGIA

What about metro- and menorrhagia? J. Novak and M. Harnik,<sup>10</sup> in 1929, reported 45 cases of psychogenic bleeding describing three of them in detail. In all the cases but one it was possible to elicit an episode of psychic trauma leading to the bleeding. Most of the patients had been unsuccessfully treated with medications. Psychotherapy of a superficial sort brought about relief. In one case it was cured by hypnosis.

Julius A. Miller<sup>11</sup> reported in detail six case histories of metro- and menorrhagia in patients of varying age that were treated successfully by psychotherapy. In one case the symptoms had been present for three years. The rôle of fear of pregnancy and coitus recurred in the psychic conflicts in five of the six cases.

In the psychotic patient there is much evidence showing the association of irregularity of menstrual flow with excessive flow often encountered.

We may tread on dangerous ground in this gynecological symptom if we assume that irregular bleeding in a neurotic women is psychogenic in origin—to be sure cancer can develop in the emotional maladjusted as well as any other. Diagnostic curettage and biopsy are imperative in all cases where irregular bleeding indicates the chance of cancer.

Psychotherapy however may offer an avenue of approach to clinical relief in the case where cancer has been adequately ruled out, and where endocrine therapy has been unsuccessful, in the case where the obvious neurosis of the patient may make a major surgical procedure unwise.

#### PAIN

In a discussion of pelvic pain and its psychogenic factors, there are some embarrassing cases that I can call to mind from among my patients. These cases are the ones operated upon for painful pelvic lesions—where minimal findings and maximum discomfort were present and in which relief from other means such as rest, heat and other forms of palliative treatment had failed to bring relief. The discrepancies between pelvic pain and the magnitude or extent of pelvic pathology has been called to our attention in the text book discussions of endometriosis.<sup>12</sup>

My first acquaintance with the possibility of psychogenic aspects in pelvic pain occurred with the following case.

#### REPORT OF CASE

CASE 1.—This patient, age 33, married 11 years was seen for right sided, sharp, intermittent abdominal pain that was definitely increased by activity. It had been present for two years and she, at one time previously, had been hospitalized for the possibility of an acute ap-

pendix. Her menstrual periods began at the usual age, were slightly irregular in occurrence with some irregularity as to the amount of menstrual flow. There had been one pregnancy six years previously which had ended in an induced abortion which she freely admitted was due to the fear of delivery. The blood count varied on several occasions from 8,000 to 11,000, the sedimentation was normal. This patient was observed for four months during which time she was studied thoroughly by an internist and had had one hospital admission with a complete gastro-intestinal x-ray. Other than hypermotility of the intestinal tract there were no suggestive findings. During this time the patient was definitely incapacitated because of the pain and finally, after consultation with another gynecologist, there was a feeling that a minimal lesion of endometriosis or inflammatory disease was present in the pelvis to account for the pain. A laparotomy was done after a curettage, both tubes were normal and both ovaries appeared to be perfectly normal. There were two small fibroids in the anterior wall of the uterus approximately 2 cms. The culdesac was free from adhesions although there was a very small lesion about ½ cm. in diameter that had a suggestive umbilication of endometriosis in the left utero sacro ligament. A hysterectomy was done, the area of the left utero-sacro ligament was resected. The pathological report stated two fibro myomata but no evidence of endometriosis in the resected portion of the uterus. The patient made a satisfactory recovery although she was extremely nervous and agitated and very despondent. Five weeks following the laparotomy the agitation and depression had increased to the point of where the patient was put in a sanitarium because of an abortive attempt at suicide.

*Comment.*—I am certain that the complaints of this patient would have been much better handled by early psychiatric attention rather than gynecological surgery even though every attempt was made to be sure of our ground prior to surgery. Consultants who had been called into the case were sincere in their belief that the condition was due to physical changes and at no time was there any attempt to promote the indication for surgical procedure.

The question of pain production has always brought up the question of the threshold of preception—the combination of minimal findings with well established pelvic pain should encourage at least some search into the anxieties of a patient to determine if they may intensify the symptoms of the minimal lesions.

#### LEUCORRHEA

The literature is particularly rich in reports of the association of leucorrhea of psychogenic origin. O. Bunemann,<sup>13</sup> in 1921, reviewed a number of cases of leucorrhea cured by suggestive therapy. In one case he reported, 12 years of local treatment without relief. To convince himself of the origin in this one case he brought back the symptom of hypnotic suggestion after the patient had been relieved for a year and then eliminated it again by the same means.

Walther, Sellheim and Lowenstein all have reported series of cases of leucorrhea of psychogenic origin. The diverse psychic factors often so closely preceded the appearance of the discharge that the association was very close.

In 1929, at the German Gynecological Congress when leucorrhea as a symptom was discussed in detail the psychogenic component in the etiology was definitely admitted.

A recent incident among my patients shows some suggestive association.

#### REPORT OF CASE

CASE 2.—A young woman, was seen for a trichomonas vaginalis that had been treated for eighteen months at more or less frequent intervals, with periodic recurrence, by one or more gynecologists. She decided to again change gynecologists because the last treatments had been very painful and came under my observation.

During a six month period no trichomonas were found although from time to time a profuse and annoying

leucorrhea would recur at sharply defined intervals—she was asked to remember when these occurred and to pay attention to the incidents that preceded the appearance of the discharge. The next time she returned to the office she related that her mother who lived with her had for years caused trouble in her home—the patient objected particularly to her mother's scolding of her older son and had arranged for him to be away much of the time. On the preceding weekend when the boy was home a particularly heated scene developed between the patient and her mother, during the height of it she noticed the sudden appearance of a large quantity of mucous although she had been free from it prior to that time and had no evidence of discharge when seen a few days later. She was firmly convinced of the association of the discharge with the unpleasantness in her household and has been entirely free from trouble since.

A. Mayer,<sup>4</sup> in discussing the origin of this symptom, gave the following explanation—"Unconscious sexual ideas are as likely to lead to hyperemia and hypersecretion in the genital region as are conscious ideas, the physiological effect of which is well known."

The pruritis vulvae group furnish additional association of psychogenic factors in gynecology. There are many cases on record of relief by psychotherapy that had defied all other means.

During the past year, five cases have been treated by breaking up the vicious cycle of the scratching and by having the unsatisfactory sex life of the patient treated by a psychologist. With all cases the question of masturbation, both conscious and unconscious was discovered.

#### REPORT OF CASE

CASE 3.—The last case gave the history of a frigid marriage; a circumcision of the clitoris, and three years of estrogenic therapy hypodermically and locally. The admission of masturbation during this period with an intense feeling of guilt and the fear that it was producing severe local injury to her were elicited. Progress is being made in clearing up a most distressing symptom picture by psychotherapeutic means under the direction of a competent psychiatrist.

#### DISCUSSION

The foregoing discussion does not furnish absolute proof that these often-seen gynecological complaints are entirely due to psychogenic factors. To disregard the personality problems of the patient or to fail to take into account the neurotic accentuation of any symptom picture where neurosis exists will continue to show discrepancies between pathology and symptom picture.

A plea is made to include into routine history taking the simple questions that show attitudes of the patient towards many of the problems of adjustment to normal living. Greater emphasis should be placed on marriage relationship and attitude towards pregnancy, coitus, contraceptives, etc. In spite of the fact that a one-hour interview has distinct limitations and that the later interviews may alter or completely change the initial impression, the estimation of the incidence of the neuroses in the makeup of the patient will go a long way towards putting a proper value upon the symptom picture and help correlate the findings. It is well to keep in mind that psychiatric consultation prior to surgery may prevent the needless or often poorly timed laparotomy.

It is well to appreciate that a psychiatric consultant is being placed in many large and progressive gynecologic clinics for the purpose of studying the personality backgrounds of patients and to help correlate the symptom picture with the clinical and pathological findings.

Objections have been raised and rightly so against psychotherapeutic treatment by the doctor who treats organic ills as well. It is often impossible because of limitation of time to do much for the neurotic patient. This fact however does not justify the indifference of the clinician to the emotional aspect or the psychogenic factors either as a cause of symptom production or as a

factor in accentuation of symptoms that may be produced by minimal pathology.

Max Mayer of the Mt. Sinai Clinic<sup>14</sup> has presented a sound idea when he reasons that these cases are not either organic or psychic problems, but often a combination of both. He says the psychiatrist or psychoanalyst "can give sympathy, support, and a point of orientation; can tend to modify the environment, if necessary with the assistance of social service; can assist in the acceptance of reality; can try to remove or alleviate anxiety; can build up general resistance, strengthen the ego to compensate for frustrations, and can use the various forms of symptomatic and suggestive therapy in cases that do not lend themselves for obvious reasons to formal psychotherapy. Such suggestive therapy is used in conjunction with the use of local treatment such as pessaries, hydrotherapy," etc.

Mayer, in his timely article, based upon his work at the Mt. Sinai Clinic, came to the following conclusions why gynecologists should know some psychotherapy.

1. To be able to elicit a psychanamnesis.
2. To avoid certain difficulties in the case management of sick women.
3. To know when to supplement his gynecologic therapy with psychotherapy.
4. To use the latter prophylactically, as in premarital instruction.
5. To understand the dynamics of many of his medical and surgical cures.
6. To know when and where not to recommend formal psychotherapy such as analysis.
7. To know when to avoid the subject.
8. To know more about himself.

#### SUMMARY

1. There is developing in the literature a growing evidence of psychogenic factors in the etiology of many gynecological complaints.
2. Frigidity and dysmenorrhea have well recognized psychogenic factors in their etiology.
3. The triad of bleeding, pain and leucorrhea may have psychogenic factors that either produce or accentuate the symptom.
4. A plea is made to include into routine history taking, questions that will bring insight into possible emotional conflicts of the patients.
5. Much work will be necessary in the future to bring clarity and understanding in the field of symptom production, where psychiatry and gynecology meet and in many cases overlap.

1930 Wilshire Boulevard.

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## NEUROSES OF WAR WIVES\*

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Hollywood

WHEN Congress declared the existence of a state of war, and then, in its infinite wisdom, determined that babies born before September 15, 1941, were conceived prior to Pearl Harbor, it inaugurated a series of manifestations which, for want of a better term, may be called "War Neuroses." It is our purpose here to examine these neuroses insofar as they affect the pregnant woman, and to consider how their effects may be mitigated.

Even a cursory study makes clear that these phenomena are not new. They are entirely analogous to the humor of the broadcasting booth, in which old jokes with a new "twist" hide the fact that there are no new stories. Similarly, the neuroses observed during a time of war are merely the same well-known hob-goblins with different scenery. It cannot be denied, however, that a number of shy neuroses, emboldened by novel surroundings, have appeared to strut upon the stage in the hope that they will be considered new starlets in the firmament of phantasy.

## INITIAL MANIFESTATIONS

To consider "war neuroses" in a somewhat chronological order, return, please, to the edict of Congress that would separate the sheep from the goats as of September 15, 1941. How many of you were importuned, backed up with tears if necessary, to induce labor when that event seemed dilatory? In extreme instances, the need for a child by the dead-line date was thought to be so great that premature labor was demanded, regardless of risk, lest a frail young mother be forced to curtail her expenditures in a manner to which she had no intention of becoming accustomed, the Fates and an obstetrician willing. Previous speakers have detailed some of the vague symptomatology presented by mentally-disturbed individuals who chance to be pregnant. I venture that none of these were missed in this group. Late vomiting, extreme heartburn, attacks of faintness, intractable constipation, and all the other complaints of the constitutionally-inferior individual were paraded forth. Staunch indeed was the accoucheur who maintained his balance in such emotional storms.

Possibly next in order should be mentioned the wife of the ideal of America, the 1-A man. How many of you were asked to certify that a newly-pregnant wife, with "pernicious" vomiting at the moment, needed the presence of her husband to carry her by a critical stage in her history? And how often did the vomiting recur as the period of grace granted by an impressed Local Board neared an end? Or, if pregnancy were near term, how many of you requested deferment until after the delivery date, and then were asked to certify that the well-being of the freshly-fledged mother would be jeopardized if the husband were inducted?

## "NORMALCY" OF PREGNANT WOMEN

The point may well be raised that these are but evidences that, irrespective of the need for racial improvement, pregnancies occur in neurotics. This is unquestionably true. Like the rain, which falls alike upon the just and the unjust, "blessed events" are no respectors of persons or personalities. If undue emphasis here is laid upon the unfit, it is because these constitute the group

under discussion. Years ago, in lectures to nurses, I used to say that the pregnant female was not a normal person, *if she ever was*. For the past few years, I have begun to wonder if what was remarked in a cynical mood was not closer to fact than had been appreciated.

## EMOTIONAL REACTIONS IN SERVICE WIVES

Previous speakers have adequately discussed the emotional attitudes toward pregnancy. Again to recount these may seem repetitious, but is unavoidable to some extent. Pregnancies occurring in a group of service wives entail not only the mental disturbances ordinarily encountered, but also a number due primarily to the disruption of the home. Consider the psychical strain of an unwanted pregnancy in a young woman whose family life has been interrupted. The absence of her husband, who probably has been the stabilizing influence in her life, serves to exaggerate her fancied symptoms. Vomiting will be prolonged and excessive, and the accepted treatments prove of no avail. Years ago the late Whitridge Williams employed a régime of inserting dulled needles under the breasts of chronically vomiting girls, and then over-distending the submammary tissues with salt solution under considerable pressure. The treatment was brutal, but seldom had to be repeated. As he expressed it in his pithy fashion, "It gives them something else to think about, and they are afraid to vomit." To resort to such drastic measures cannot be advocated, but if the attendant bears in mind the basis for over-complaining he may be able to give the patient "something else to think about," even if he cannot entirely eliminate the underlying emotional conflicts.

## ON CHANGES IN FAMILY RELATIONSHIPS

Quite a few difficulties arise entirely from the changes in family relationships caused by the war. One of these concerns the desire for a child as a replacement for the lost companionship of the husband. Unless pregnancy is secured promptly, the wife appears in the physicians' offices demanding investigation and results. Too often there is but little one can do for these poor frustrated souls. They cannot bring themselves to accept the facts placed before them. One will carefully outline the procedures contemplated over a period of months, and the response will be "How much of this can we get done this week?" Their very urgency militates against success. A single finding deemed by them as unsatisfactory and they betake themselves elsewhere. Torn and tormented by denied hopes, they live from month to month, from camp to camp, and from doctor to doctor.

## STERILITY

Sterility is a problem that is extreme in its complexity. Its study should include a careful urological survey of the male side of the question, and with the husband at a basic training center or out on maneuvers, the possibility of securing such information is much reduced. Not all urologists care to undertake these investigations. When the urologist available to the serviceman is possibly some one assigned to that division and without any real qualifications, the reported findings lack in detail and in reliability. The ovulatory phase in the wife's menstrual cycle will seldom coincide with the husband's occasional leaves from camp. Above all is the increasing tension. Next month may be too late. What can be done must be done at once or sooner. In the mind of the wife, she has already received the dreaded wire from the War Department, and with the expected orders for overseas duty, she mentally goes into premature mourning.

In 1942 the Pacific Coast Society of Obstetrics and Gynecology held a symposium on "Obstetrics as Affected by War Conditions." In that discussion, T. Henshaw Kelly of San Francisco, remarked that "the theme-song

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of the girl of today seems to be 'Please Give Me Something to Remember You By.' The song is out of date; the idea still prevails.

#### FINANCIAL FACTORS

Reduction in family finances oftentimes has entailed real financial hardships and is frequently advanced as a reason for avoiding pregnancies. Many service wives find it necessary or convenient to work while the customary provider can supply but \$50.00 per month. Under these circumstances, a pregnancy is regarded as a catastrophe of the first magnitude, and the fear that such might occur results in a pronounced change in marital relationships, with, of course, alterations in subconscious attitudes evident even to one not versed in the psychiatrists' vocabulary. The attempt by the Federal government to provide free attentions for maternity is only a partial solution and has provoked other disturbances as will be mentioned later.

#### ON ABSENCE OF HUSBAND

Whether because labor is one of the greatest achievements in a woman's life, or because she has been impressed by the warnings of her sadistic friends, a woman usually wishes her husband at hand while she passes through the valley of the shadow. The certainty that he will not be present arouses resentments in some, self-pity in others, fears and phobias in still another group. Quiet counseling by the obstetrician will do much to comfort these girls. An explanation as to what labor really is, and as to how the patient can help herself, frequently will give her a more joyful approach to motherhood.

#### EMERGENCIES—ACTUAL VS. UNREAL

A rather frequent bit of misinformation given out by well-meaning friends is the suggestion to the service wife that if the doctor will but send a wire stating that her condition is critical, the Red Cross will get her husband to her in rapid order. *In an emergency*, the Red Cross will do exactly that. It will cut red tape, establish travel priorities, advance funds, and perform a whole host of needful services with a minimum of lost motion. *But*—an emergency must first exist, and when the doctor explains that he cannot produce an emergency to order, as it were, the disappointment that this will not be done is tremendous. Oftentimes the wife comes to feel that her physician, in whom she needs to trust implicitly, is lacking in sympathetic understanding of her peculiar problems. Here again, careful and complete explanation is helpful in readjusting the accord so necessary between patient and physician.

#### ILLEGITIMATE PREGNANCIES

A series of emotional conflicts, fortunately encountered infrequently, is based upon fear that the husband may return to find his wife pregnant from extramarital experiences. Illegitimate pregnancy is a problem that has existed since the institution of marriage was established. It is based upon a variety of economic, sociologic and educational factors, and war, as such, has but minor significance. Indeed, save in the conquest and rape of subjugated peoples, it is difficult to postulate that war conditions affect the potentiality of illegitimacy. The one factor which influences the *actual* incidence of illegitimacy is that of opportunity. The girl or woman of a promiscuous frame of mind retains her promiscuity in spite of all restrictions. During war, restrictions are lessened, and opportunities are more easily created. Once the glamour of the moment has subsided, and the unwelcome fact becomes apparent that pregnancy has resulted, there are pronounced psychical disturbances. Usually these are characterized by resentments and antagonisms. The hus-

band is blamed for not being at hand to protect the honor of his wife. The government is blamed for taking the husband from his rightful sphere. The errant lover is blamed for having taken advantage of a situation, and for his freedom from responsibility for his crime against womanhood. Finally, the doctor is blamed for his refusal to commit a further crime, abortion, a step which the wife feels is fully justified. It seems specious to point out that the energy and time given in trying to assist these women in a readjustment of their attitudes is largely wasted.

#### SERVICE WIFE FIXATION

One further attitude of the service wife deserves particular mention, and that is the resentment that she *IS* a service wife. She feels that she is considered a charity patient. For that reason, she is convinced that things happen to her that do not occur with others in her condition. If her physician is detained in the delivery rooms and is late in meeting her appointment, it is because he doesn't mind inconveniencing her. If her analgesia fails to meet her expectations, it is because the nurses are callous to her suffering. She has built up the idea that the war has taken her home life from her, and that she is being sacrificed on the altar of Mars. No matter what happens, every ache and pain and discomfort is a further sacrifice required of her and her alone.

#### RESENTMENTS PROVOKED BY CHILDREN'S BUREAU PUBLICITY

In mentioning the conflicts arising from a fear of pregnancy because of financial status, the rôle of the Federal Government was noted. You are, no doubt, familiar with the E.M.I.C. program. Wives of service men of the lowest four grades are assured, in numerous publicity items from the Children's Bureau, that the costs of maternity will be paid by the government. It is emphasized that the eligible wife may go to the obstetrical attendant of her choice. She is not informed that many physicians refuse participation in the program on the principle that no agency should stand between the patient and her doctor; that others, particularly in the larger centers, find the permitted fee too far below their actual costs to allow them to enter into such practice; and that still others, including many over-worked general practitioners, are entirely too busy caring for their own clientele to accept any and all applicants. If she has remained at home, she has as a rule no difficulty in securing attentions from those who normally would be consulted were her husband out of uniform. It is the transient patient, following her husband from place to place, whose efforts to find needed services are oftentimes unsuccessful for the reasons noted above. Her resentment is aroused by being denied the type of care promised her by the Bureau. Usually her resentment is directed against the medical profession, a fact which becomes of more importance in view of the prominence of the question of governmental regulation of medicine.

#### SEMI-PSYCHIATRIC TENDENCIES AMONG SERVICE WIVES

Unfortunately, the frequency with which service wives present semi-psychiatric tendencies makes such patients even less desirable. The conscientious physician finds that they average more time per visit than his other patients. The financial loss entailed is of much less importance to many than is the loss of time. Even the Santa Claus Children's Bureau, which cheerfully gives away our services, cannot provide us more than twenty-four hours a day.

#### DISEASE AND "DISORDERS"

The end result, then, is that we are not properly caring

for the mental maladjustments of our patients, whether service wives or not. For headache, we suggest empirin if aspirin has been used, and aspirin if the patient has been taking empirin. Various barbiturates are relied upon to relieve sleeplessness. We are treating symptoms only, and the canker continues to fester below the level of our consciousness. We understand disease better than we do disorders. Until and unless we take the time necessary to apply the teachings of our psychologist and psychiatrist confreres, we will continue to be of little real help to those of our patients who suffer from fears, phobias and fantasies.

#### THINGS TO REMEMBER

One fact stands out clearly. The uncertainties under which service wives carry on their lives breeds further unrest in their minds and souls. They cannot know where next month or even tomorrow may find them. The search for quarters is always arduous and sometimes impossible. They live under strains that we civilians can only guess, and their fortitude, rather than the occasional imbalance that here we emphasize, is most remarkable. If occasionally they lapse from accepted behavior, we should never forget that "battle fatigue" is encountered also on the home front.

Equitable Building.

### THE SIGNIFICANCE OF PSYCHOANALYSIS FOR GYNECOLOGY\*

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Los Angeles

THE papers just presented in this symposium amply demonstrated the significance of psychogenic emotional factors in gynecology and obstetrics. It cannot be otherwise, since, to quote Dr. Holmes, "In an obstetrical practice, one sees a cross-section of life—birth and death, hope and despair—comedy and tragedy"—. And the gynecological practice deals, I might say, with the essence of life—with love. The gynecologist is called upon to help women sustain or restore their capacity to love—to be happy and to make others happy. The gynecologist is the custodian of the female reproductive organ system, the normality of which guarantees normal wives, normal mothers, happy marriages and normal children.

Viewing gynecology in this wide perspective, the specialist is faced with the necessity to take psychogenic factors into consideration, not only for an understanding of the pathogenesis of the gynecological syndrome, but also for the indications of his therapeutic approach.

I know that the good specialist has always been a good doctor in general. He has never forgotten that in many cases it is not only the special organ system of his patient which requires care—that behind the ear and the eye, the nose and the throat—and behind the uterus, there is a human being, who suffers.

#### HOW PSYCHOANALYSIS HAS HELPED

Before Freud and before psychoanalysis, the doctor who tried to help his patient by appealing to the emotional part of his personality, had as his tools only his good will and his intuition. Through psychoanalysis the physician has gained scientific knowledge about the psychodynamics of the personality because psychoanalysis disclosed to him the realm of the unconscious, the source of instincts and human passion. All psychopathological phenomena, such as neuroses, psychoses, functional organ disturbances originate in the unconscious strata of the

human mind. Freud made the unconscious amenable to a scientific understanding and to the physicians' therapeutic endeavor.

For experimental proof of the fact that unconscious ideas influence and alter bodily functions, we need not look only to psychoanalysis. Hypnotic experiments furnish sufficient evidence. Let me cite one such experiment. You cannot persuade an individual to alter his skin texture by his conscious volition, but if you hypnotize the person and plant into his unconscious the suggestive idea that he has burned his finger, he will develop a typical blister.

#### AUTHOR'S PURPOSE.

Doctors Judd and Holmes frequently alluded to the fact that disturbances of the functioning of the female reproductive organ system must come about through interferences of *unconscious* ideas which are in contradiction to the conscious wishes and ideals of the individual. They as well as many other physicians employ a psychoanalytic concept in their psychotherapeutic approach. Thus it is apparent that psychoanalysis is of great significance for an understanding as well as for the treatment of psychogenic factors in gynecological syndromes. It is my task to present some of the psychoanalytic theories and experiences in order to demonstrate *why* psychoanalysis deserves an important place in the armament of your specialty.

I might preface my remarks by warning you that as far as emotional factors in gynecology are concerned, I may place as much or even more weight on the significance of hate than of love in the psychopathogenesis of gynecological disorders. For there are two instincts which determine human emotional life—the sex instinct with its mental manifestation of love, and its antagonist, called by Freud the death-instinct, with its emotional representative of hatred. It is very often unconscious ideas of hatred which interfere with the individual's capacity to love, disintegrating the physiological functioning of the reproductive organ system.

#### PSYCHOSOMATIC MEDICINE

Let me first say a few words about psychosomatic medicine in general. It is the latest and most comprehensive branch of modern medicine, which concerns the dynamic interrelationship between bodily functions and mental processes. Psychosomatic medicine tends to provide us with an objective approach by which we can understand and influence bodily functions by psychotherapy or influence mental processes by organotherapy. The autonomic nervous system administers the affect dynamics and economics of our mental system. Thus, in association with subcortical brain centers and the interrelated endocrine glands, it furnishes the physiological apparatus interacting between brain cortex and outer motor nervous system, that is, between impulse and action or between inner mental life and external reality.

What is the significance of psychoanalysis for psychosomatic medicine? There is no psychosomatic medicine *without* psychoanalysis because there was no scientific psychosomatic medicine *before* psychoanalysis.

#### MEDICAL PSYCHOLOGY

Scientific medical psychology factually came into being through Freud's psychoanalytic discoveries, this for various reasons: 1) through psychoanalysis we learned to understand symptomatic disturbances of organ functions as manifestations of a disturbance of the personality as a whole; 2) in disclosing the nature of the hysterical conversion symptom, Freud found that the ego sends energies into the innervations of inner organ systems, which have been diverted from outer motor dis-

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charges; 3) mental processes are responsible for this shift from outer motor innervations, from action impulses to inner motor innervations, into the organ system; 4) these mental processes reflect *mental conflicts*, which impel the individual to abstain from certain actions although his instinct drives are in need of an affectual discharge; 5) these mental processes, representing conflicts, occur *unconsciously* and are beyond our conscious control.

The conscious ego decides our actions. But our conscious volition is not free; it is determined by processes in the unconscious which, under certain conditions, exert their influence on the ego and might compel it to abstain from action—to withhold certain nervous energies from outer motor discharge and instead canalize them via the autonomous nervous system into bodily functions or, as Freud phrased it, "to bring about an alteration of a part of our body instead of altering a part of our surrounding world."

The great significance of this discovery is that it is inner unsolvable conflicts with an external object or with our inner conscience which cause the ego to shift outer motor action impulses into its "inner motility" and that these conflicts must occur unconsciously in order to create pathological disturbances in the organism. The treatment is based on the possibility of making an individual conscious of such conflicts and in this way to refer them back where they belong—to shift them from the soma to the mind. The possibility of a permanent or temporary cure depends on the degree to which the patient becomes capable of solving his conflicts on a conscious level. Psychoanalytic treatment gives back to his ego conscious control over his action impulses. It is then up to his insight and judgment to act them out and to change a part of his surrounding world instead of a "part of his body"—or by abstaining from acting out in conformity with his conscience, to sublimate his undischarged instinctual affect energies.

The impulses which are able to bring us into conflict with the object of our environmental world emanate from the sources of two main instincts, as mentioned before—the sex instinct and the destructive instincts. The sex instinct is, the biological source of the affect of love in its broadest sense; the destructive instinct is the source of the affect of hate. Since the instinct is originated in our soma but manifests its drive in our mind, the study and knowledge concerning instinctual drives gives us the opportunity proper to study the interrelationship between mind and body, which is psychosomatic medicine.

#### MENTAL DEFENSE MECHANISM

Before I apply these general remarks on psychoanalysis and psychosomatic medicine to gynecology, I must ask your indulgence for dwelling on a specific psychoanalytic phenomenon which Freud calls "mental defense mechanism."

The ego of an individual who is entangled in unsolvable mental conflicts must defend itself against anxieties resulting from the inner perception of damned up dangerous instinctual drives. In order to keep itself adapted to the demands of reality, the ego employs various mechanisms of defense. Of particular importance for the understanding of psychosomatic phenomena is the defense mechanism of *repression*.

Repression, in psychoanalytic terms, signifies banning from the conscious part of the ego every thought which is too painful to bear and every instinctual drive, the gratification of which might bring us into dangerous conflicts. Repression, in the psychoanalytic sense, means that these ideas descend into the unconscious part of our mind and in this way are prevented from gaining access to the outer motor center of our brain cortex. The ego defends

itself against its dangerous action impulses by shutting off from consciousness the ideational content of its instinctual desires. However, the conflict does not cease to exist—it merely becomes introverted, and then, from the unconscious strata of the mind, tends to release the affect charge of repressed ideas and instinct wishes beyond conscious perception.

As we know, every affect has its physiological as well as its psychological manifestations. For example, the mental perception of anxiety is associated with a deepening of respiration and an acceleration of the heart beat. Besides, discharge phenomena like outbursts of perspiration or diarrhoea often help to diminish the mental tension aroused by the affect. What we have learned from psychoanalysis is that an individual may experience such alterations of organ functions without being aware of his anxiety, because the ideas pertaining to this affect are hidden in his unconscious. He may then believe that he is suffering from a heart condition or from tuberculosis, because of his frequent perspiring, or from a gastro-intestinal disease, whereas he is really suffering from an unconscious emotional anxiety tension, due to an inhibited discharge of instinct energies into the outer world of objects. It is important: that the gynecologist take such conditions into consideration. For the unconscious anxiety affect may seek a somatic outlet not only through biological pathways, such as those mentioned, but may also take advantage of organic discharge possibilities which present themselves under certain conditions. I know from personal observations, that profuse leucorrhoea or menorrhagia can be physical equivalents of latent anxiety tensions.

We see that under the condition of repressed unconscious affect laden ideas organ functions may have to serve two masters: they must fulfill their physiological task for the sake of the entire organism, and at the same time they must take care of a surplus of mental affectual energies which cannot find an adequate discharge either by their inner somatic biological mechanisms or by actions.

Moreover, the unconscious selection of organs for the placement of repressed instinctual drives is not fortuitous. It is basically determined by repressed, unconscious wish phantasies and often associated with infantile irrational concepts of bodily functions. The alimentary system, e.g., might be disturbed in its functioning because its biological task is interfered with by an unconscious wish to experience a gastro-intestinal impregnation. Thus the alimentary system starts dysfunctioning—it becomes "hysterical" and develops an organ neurosis.

#### UNCONSCIOUS WISH PHANTASIES

Irrational phantasies against impregnation through the mouth were developed at a time in childhood when the immature child had neither a correct concept of himself nor of his environment, i.e., of reality. When the child is unable to adequately satisfy his instinctual needs from the outside world, he substitutes actual gratification through imagination and indulges in phantasies which deny a frustrating reality.

In these phantasies the child tends to satisfy his unrequited love and his unsatiated hatred. Certain of these infantile phantasies are typical and correspond to certain stages of infantile sexuality. Since they have been originated in unsolvable infantile conflicts with the environment, the child repressed their ideational content into the unconscious, where they may remain stored up, laden with instinct affectual energies which interfere with the healthy maturing of the personality.

#### DEVELOPMENT OF MENTAL MATURING

In the developmental process of mental maturing, the child must acquire the difficult capacity to love by sub-

limiting his innate tendency to hate and destroy in reaction to love frustrations. Love is the emotional representative of the sex instinct. But the sexual instinct does not manifest itself primarily in puberty—in puberty it only becomes capable of serving the biological aim of reproduction, through the maturing of the gonade glands. The sex instinct is operative from the very beginning of life and manifests itself in pleasurable sensations, which the infant derives from the various organ zones of its body. The infant drinks milk not only because he is hungry, but also because he gains pleasurable oral sensations, and in addition feels secure in being taken care of. Likewise, the child gains rectal pleasure in emptying his bowels, as well as at times keeping back the feces. Baby care, such as diapering, drying, powdering, all give him pleasurable sensations. Eventually the infant discovers his genitals and playing with them gives him pleasurable sensations too. Out of the summation of pleasurable sensations derived from the various erotogenic organ zones, the child eventually discovers his mental ego and loves himself. This happy autoerotic or narcissistic existence, as we call it, is very soon disturbed by the fact that in the fourth year of life, the child develops sexual differentiations in his love striving and directs them toward the parents—the boy is obsessed by strong sexual demands toward his mother. Wanting to possess her completely, he conceives of his father and siblings as rivals. The little girl falls in love with her father and conceives of her mother as her rival. Wish phantasies of hate and destruction of the parent of the same sex come up and cause anxieties and feelings of guilt. Most children at this period also wish to reproduce babies with the parent of the opposite sex, without knowing how to accomplish this.

This typical infantile conflict through which everyone passes is the so-called Oedipus conflict. It would be beyond the scope of this paper to show you how we normally overcome this difficult conflict of our childhood, when our first genuine sexual desire requires a complete renunciation. Today we are interested only in the pathological after-effects of this Oedipus conflict, the effects of its incomplete repression in the unconscious, where it remains alive as an Oedipus complex.

#### ✓ PSYCHOSEXUAL DEVELOPMENT OF THE FEMALE

Since we are dealing with the psychopathological problems of gynecology, our interest is solely focused on the psychosexual development of the female. The psychosexual development of the girl is beset with *specific* psychobiological difficulties which create a disposition to failures in the mental or physical development to mature womanhood.

Before the time when the little girl falls in love with her father, she goes through a period when she dislikes her own sex and would like to be a boy. This period is called the *phallic phase* of development. During this time, the infantile sexuality of the girl is restricted to sensations from the clitoris. Clitoris sexuality is of active driving character—i.e., male quality. Vaginal eroticism, which is of passive receptive female quality develops fully only in puberty and very often is actually established through the first sexual intercourse. It is at her phallic period that the girl suffers from *penis envy* and has the idea that nature, or rather, her parents, particularly the mother, have cheated her. The boy has a penis which he proudly displays and with which he can actively direct his stream of urine. He is taught by his mother how to touch and handle his penis for such purposes. The little girl is forbidden to touch her genitals, or even to know that a genital source for pleasurable sensations exists.

The little girl feels herself castrated, and develops phantasies of comfort that some time in the future she

too may grow a penis. This phantasy of being a *castrated* boy is especially intense and traumatic if the girl actually, as happens not seldom, was exposed to a castration threat. For instance, she might have overheard her little brother being threatened with castration for masturbating. To her it is then logical that she is a castrated boy is especially intense and traumatic if the girl actually, clitoris. At this early age, gynecological examinations have a particularly traumatic effect, because to the little girl these examinations are a punishment and a confirmation of her fear that she is damaged for life. Penis envy and hate against men as penis bearers assumes enormous proportions when the parents indulge in the glorification of the boy as their male offspring or, as happens not so seldom, even tell the little girl how disappointed they were when she was born, because what they wanted was a boy.

#### ✗ INFLUENCE OF NEUROSES OF PARENTS

Of particularly traumatic influence to the psychosexual development of the girl are the neuroses of the parents, which precipitate neurotic complexes in their children. A mother who never solved her own masculinity conflict and has never accepted her feminine rôle might perhaps react by denying her daughter all sexual information, or might misinform her by telling her that intercourse is disappointing or disgusting, "men are beasts in sex." The father, still unconsciously fixated toward his own mother, might have developed a sexual taboo toward his wife when she became a mother and unconsciously transfers his latent incestuous feelings to his daughter as a mother-substitute. Without realizing it himself, he may overstimulate his daughter's infantile sexuality by too much affection, by too much caressing.

The girl who has not been exposed to such traumatic influences, can develop normally. This implies that, strange as it seems, penis envy is transformed into the wish for a baby. It is as though the possession of a penis loses its significance when and if the little girl gives up her phallic sexuality through replacing the heretofore leading erotogenic zone of the clitoris by the interior of the vagina. With the maturing of the gonade glands, the normal desire for intercourse, for pleasurable reception of the partner's penis and for *conception*, dethrones the wish for possessing a penis.

The brief sketchy outline I have presented about the psychosexual development of the girl does not reflect any theories, but is based on facts which the psychoanalyst uncovers again and again in the psychoanalysis of neurotic women. During the psychoanalytic treatment of psychoneurotic women, we encounter various kinds of gynecological symptoms which manifest their disturbed psychosexuality, organ symptoms which disappear when their unconscious meaning has been revealed.

#### ✗ DISTURBANCES OF THE FEMALE PSYCHOPHYSICAL PERSONALITY

Let me select a few manifestations of the disturbance of the female psychophysical personality. The most comprehensive disturbance is based on the fact that a woman has remained fixated or arrested in her psychosexual development at the phallic phase of her childhood. She repudiates totally or partially her own sex—her feminine rôle. Such women might substitute the wish for the possession of a penis by a general change of character. They develop masculine characteristics in their behavior and engage in all kinds of activities which are considered masculine. To phallic women, all biological manifestations of their sex are often perceived by them as an offense to their ego. They react to menstruation with depression or anger and rage. Every genital bleeding seems to their unconscious that the vagina is an open

wound, because their penis was cut off. In particular, the first menstruation is a mental trauma, because it seems to confirm castration as a punishment for infantile masturbation. Women with a castration complex are afraid of bleeding, that they will bleed to death in defecation or in giving birth to a baby.

The unconscious mental resistance against accepting femininity, partially or totally, is very often the psychogenetic causative factor behind dysmenorrhea. Painful abdominal cramps are often substitutes for unconscious pangs of conscience, signifying self punishment or, as mentioned previously, they may be just physical equivalents for hidden infantile anxieties. You can understand that in such cases it is important not only to alleviate the pain or stop the bleeding, which reflects the vain attempt of the organism to restore its psychophysical equilibrium—it is also necessary to bring the anxiety out in the open and to treat the unconscious mental conflict behind it.

Disturbances in the act of cohabitation are very often manifestations of unconscious aggressive castrative tendencies against the penis of the partner. Phallic women do not like intercourse. They consider the male organ disgusting. They are afraid of it, but they really fear their own destructive reaction against the penis. Disturbance of the orgasmic function, frigidity, and vaginism are likewise, in most cases, defenses against unconscious infantile incestuous wishes or often against the wish to destroy the man's penis. Anaesthesia of the vagina is an inner denial of pleasurable sensation from intercourse because of unconscious guilt feeling. The husband might still have the unconscious significance of the father and therefore intercourse with him is not allowed to yield pleasurable sensations.

In other cases, this inner inhibition of the pleasurable sensation is necessary because such women are *unconsciously afraid of an orgasm*. In an orgasm she might lose conscious control over her instinct strivings and might turn love into hate and destroy her partner's penis. *Vaginism* signifies a compromise solution of such an unconscious antagonistic attitude against the hatefully desired penis. The spastic contraction of the vaginal muscles has the meaning to capture the penis, but this is prevented because the spastic contraction of the vaginal muscles occurs as soon as the penis approaches the vagina, thus preventing the penis from entering and suffering castration.

The most common and general solution for these problems is found in the character of hysterical women, who love men, love their husbands, love the male body, but exclude the penis from any sexual desire. They might submit to intercourse for the sake of the husband, but they themselves do not require any sexual gratification.

#### ORGANIC DYSFUNCTIONS

The knowledge of these organic dysfunctions, caused by psychopathological unconscious mental processes, is of utmost importance to the gynecologist. It might indicate to him not only what he should do in some cases, but more what he should not do. I think the gynecologist, in knowing the unconscious mental background of the phenomena described, would abstain from teaching husbands techniques in intercourse, such as irritating the clitoris for the sake of an orgasm. He would abstain from circumcizing the clitoris to make it more sensitive, and he would abstain from diagnosing difficulties the husband might have in entering the vagina as due to an "infantile too small vagina" of his wife and from artificial dilatations of the vagina. Of course, he might succeed in making cohabitation more satisfactory to both partners, which is of great practical significance, but he must also be aware that he did not eliminate the patho-

genic unconscious mental source of the phenomena in question. The significance of treating the psychogenetic factors as early as possible, beyond the immediate aim of making cohabitation satisfactory rests on the fact that the unconscious mental complex might manifest itself later on, when the woman becomes pregnant, when she must deliver and take care of her baby.

The repudiation of femininity may manifest itself then in an unconscious repudiation of pregnancy. Continuous uncontrollable vomiting during pregnancy is very often an unconscious wish to get rid of the baby. Behind this wish is the unconscious infantile phantasy that the impregnation has come about through biting off and swallowing the penis. The equation has remained in the unconscious that the penis equals the baby. The unconscious phantasy that the baby developed in the stomach and must be discharged through defecation might disturb the act of delivery. The uterus as well as the vagina may suffer from constipation and develops a tendency to hold the baby back instead of giving it to the husband.

If you don't believe that such phantasies are created in childhood, I will tell you a little story. The three and a half year old daughter of a friend of mine developed a painful constipation for a number of days. Nothing seemed to help. The constipation set in a few weeks after her mother had given birth to a little brother. The girl once sat on the potty and was urgently asked by her father, who promised her candies, to deliver the stool. Finally, under abdominal cramps, she cried out in tears, "I do not want the baby to come out." Thus this little girl identified herself with her mother and had conceived the pregnant mother's big stomach as a container for the baby, and the act of delivery as an act of defecation. In a magic way, by taking over the rôle of the mother, she wanted to annul the birth of the brother, of whom she was jealous because he attracted too much love and attention and probably because he had a penis.

Spontaneous abortions during pregnancy may have their origins in unsolved unconscious conflicts. As far back as twenty-five years ago, I observed such a case in my practice. A woman who consciously had the ardent wish to have a baby, was stricken with profuse hemorrhages in the fourth month of her pregnancy. The gynecologist considered a surgical interruption of pregnancy indicated. I was called in as a consultant by the husband, who had studied some of Freud's writings. From a few dreams, I could show the patient that she was suffering from an unsolved conflict with her father. She was an only daughter, to whom the father was very much attached. His fixation evidenced itself in his behavior—he did not want her to marry and when she finally married against his wish, he reacted with deep depression and cursed her, wishing that at least she should never have a baby. The conscious digestion of this part of her father fixation and father conflict was instrumental in stopping the bleeding and enabling the woman the normal delivery of a boy.

Strangely enough, the excessive wish for motherhood—"the cry for a baby"—is sometimes determined by just the opposite wish, by the unconscious wish to be a man. Such ladies "protest too much." For them having a baby means unconsciously acquiring the husband's penis. They overcompensate and keep repressed the latent inherent wish for masculinity by overemphasizing the wish for motherhood.

One of my women patients could never understand why her husband reacted in such a hostile way to her when she announced to him that she was pregnant. In analysis, she remembered the wording of her communication. She phrased it: "Now, I don't need you any longer—I am pregnant." Psychoanalysis revealed that the unconscious meaning of her statement was: "Now I don't need your

penis any longer, because I have it inside of me and will produce it in the form of a baby."

The unconscious masculinity complex of women is a very common cause of unhappy marriages and broken homes. These women instead of living in coöperation with their husbands, compete with them. They begrudge him his work, his success. Instead of considering themselves the inspiration for his success, they feel that they have been relegated merely to the rôle of a servant, who must do the dirty house work and care for his daily needs. What such women actually do not know is that they have never overcome their infantile frustration of not being the man themselves. Many times they accuse the husband of not satisfying them sexually, without realizing that they themselves may be the cause, because of their frigidity.

It might be considered a healthy compromise if wives with such complexes develop their own individual professional career, independent of the husband, and leave the care of their household and children in someone else's hands.

There is no doubt that *after* giving birth to a baby the woman's attitude might also be determined by unconscious emotional factors. Their own ambivalence conflict of love and hate toward the husband and his masculinity, is sometimes transferred onto the baby. Such mothers are often afraid of baby care and particularly fear having to nurse the baby. Without being aware of it, they are afraid of their babies, afraid of what the babies can do to them. They project onto the baby their own unconscious hostility. Such ambivalence conflicts within the mother may have physical consequences for the baby, and also for the mother herself. They may lead to cessation or stagnation of the secretion of the mammary glands.

Let me give you an example. The young mother who announced that she did not need her husband any more because she was pregnant, fell sick during the first months of lactation with an extended infectious mastitis. Through nursing, the baby became infected and developed a general furunculosis. This not only deprived the baby of his mother's milk once and for all, but also made several surgical operations necessary for the mother, and for the baby. In psychoanalysis the woman remembered how she might have brought about her mastitis. Whenever the baby was brought to her to be fed, she could not help feeling afraid, so that she pulled away from him, while he fed at her breast. The baby lost the nipple and had to find it again. This little fight between the baby's mouth and the mother's nipple could be rightly held responsible for the erosions which, by way of infection, developed into an abscess.

Every obstetrician and pediatrician knows that the physiological process of lactation itself is influenced by conscious emotional upsets. There is no doubt that unconscious complexes, as described before, can likewise interfere with its successful functioning. An unconscious psychogenic influence on the activities of the mammary glands was once strikingly brought home to me when I psychoanalyzed a hysterical frigid woman, with a strong wish for motherhood. Once she dreamed that I was her baby—the baby she wished from her father—and that she nursed me. She awoke from her dream with some secretions from her nipples.

It seems mysterious, but it is an undoubted fact, as Dr. Holmes mentioned in her presentation, that fertility and sterility are also conditioned by unconscious mental influences. Psychoanalytic treatment of sterile women has proved that they become capable of conceiving after their unconscious conflicts have been made amenable to conscious mental digestion. The strange phenomenon that a supposedly sterile woman becomes fertile after adopting

a baby has been explained by psychoanalysis, at least, in one case.

Orr\* reports the detailed psychoanalytic case history of such a woman. It is as though her ego was capable of giving up her unconscious resistance and self-denial for motherhood only after she had been allowed to accept motherhood first without the procedure of her own cohabitation and impregnation, which was taboo, because of unconscious infantile conflicts. It is the unconscious wish for virginal conception by excluding the male partner, which must have found its realization first.

#### ON USE OF PSYCHOANALYTIC KNOWLEDGE BY THE GYNECOLOGIST

I hope that despite the sketchiness of my presentation, I have said enough to demonstrate *why* psychoanalysis is of great significance for gynecology and obstetrics. The gynecologist might now ask how he can employ his psychoanalytic knowledge in his practice. It is not easy to give a satisfactory answer. Certainly the gynecologist cannot subject his patients to a regular psychoanalytic treatment. Even if he were to have adequate training, he could not devote enough of his time to such treatments. However, by virtue of his psychoanalytic knowledge, he will be in a much better position to fulfill the tasks of his specialty.

He will be able to focus his interest on the total psycho-physical personality of his woman patient. In taking her history, he will be interested not only in the history of her preceding organ diseases but also in her life history, particularly that of her psychosexual development. He will inquire about her childhood, about her sex education. From this material he will be able to form an opinion about the libidinal constitution of his patient, whether she is emotionally well balanced or whether she lives, as Freud phrased it, "beyond her mental means." The latter implies that without being aware of it herself, she suffers from frustrations either because of her own inhibition or because of her partner's incompatibility.

The sleep of such women is disturbed, particularly the phase of sleep after intercourse. After normal satisfactory cohabitation, the individual is completely relaxed and sleeps well; after unsatisfactory sexual relations, the sleep is disturbed by anxiety dreams, very often manifesting more or less symbolically disguised aggressions against the partner. Above all, the gynecologist must ascertain whether his patient is entangled in an actual conflict. If this is so, he will sometimes find that the patient's symptoms are a means of escape from an unbearable reality and fulfill a certain task. The patient avoids mental agony by feeling sick and unconsciously uses her suffering to neutralize her latent guilt feeling and very often as a defense weapon against her undesired partner. As an example, I mention menorrhagia, occurring whenever the husband demands intercourse, which the woman tends to avoid out of suppressed guilt feelings, perhaps because of her erotic interest in another man.

The few illustrations I gave you may suffice to show that a thorough knowledge of psychoanalysis will enable the gynecologist to arrive at what we call a *psychodynamic diagnosis* of his patient's total personality. Such a diagnosis provides him with indications for his therapeutic approach. If he discovers that the patient's organ disturbances are localized manifestations of a general psychoneurosis, he will refer her for treatment to the psychoanalytically trained psychiatrist, at the same time keeping her physical condition under observation. If he concludes that the patient's symptom is a physical reaction to an unbearable situation, he might apply psycho-

\* Orr, Douglass W.: *Pregnancy Following the Decision to Adopt*. Psychosomatic Med.: 3:441-446 (Oct.), 1941.

therapy himself, if he has the necessary psychoanalytic knowledge.

This psychotherapy in the office of the gynecologist can benefit a great number of patients because psychosomatic disorders are fortunately often not caused by deeply repressed unconscious complexes but precipitated by thought and affect material which is only *preconscious*. Thought material is termed *preconscious* when it is *suppressed* and shifted away only temporarily from the conscious perception of an ego which is unable to understand or interpret a specific conflict situation.

You will be astonished at the number of women, who only because they lack knowledge about what I might call the psychological facts of life, react with organ disturbances to the tasks of womanhood. Their emotional reactions to actual conflicts with the parents or the partner are suppressed, due to a lack of intellectual understanding or the incapacity to verbalize their impressions. Such patients get relief from their physical symptoms if they are made to understand their own and their partner's organ functionings, and provided with the adequate verbal concepts to vent their pent up emotions.

Even in cases where the gynecologist can help the patient to understand and digest her conflict, only insofar as it is the conscious end of a deeper unconscious conflict, he might at least alleviate her organ symptoms. What the gynecologist does here is to demask the psychological meaning of a somatic symptom, so that the organ can no longer be misused for mental economic purposes. The psychoanalytically oriented physician will talk relatively little himself in such psychotherapeutic interviews. He will rather be the listener. Of course the most important and most difficult task for the gynecologist is to decide when to stop his psychotherapeutic approach or refrain completely from psychotherapy, because his patient needs the care of the psychoanalytic specialist.

I cannot accept the usual objection that the busy physician does not have time for such psychotherapy. It is true he must set aside a number of appointments for such patients outside of his office hours, appointments which may last one hour each. By doing this, however, he may save himself and his patient many weeks or months which otherwise would have been used for organ treatments. He might even spare his patient the prospect of becoming a life long gynecological patient. For there are women who become libidinally fixated to their doctors and produce or cling to symptoms because the gynecological treatment itself provides them with a latent gratification for unconscious instinctual needs.

I am convinced that in the future, when psychoanalytic knowledge has become an integral part of medical training, there will be a change in the method of medical practice. At the present time the daily schedule of the doctor is divided between office hours, home calls, surgery and other hospital work. In the same way as the doctor now sets aside more time for surgery than for patients seen during office hours, so in the future will he introduce another sub-division into his schedule, this for psychotherapy.

#### IN CONCLUSION

In conclusion, I might say that the gynecologist, in his special field of psychosomatic medicine needs psychoanalytic knowledge in order to understand the manifestations of the unconscious in his patients. With this knowledge, he will be aware of how often the body is an instrument of the mind and that the body speaks an organ language, which conveys a message from the unconscious ego of the patient to her conscious ego. By understanding this message, even if he does not translate it to the patient, the gynecologist gains a new perspective for his indications and a new stimulus for his therapeutic endeavor.

555 Wilcox Avenue.

#### Cost of Battleship for Research in Medicine

No one is concerned about the cost in dollars of the American fleet that recently pounded the Japs into submission. Whatever the cost, we deem it worthwhile. Battleships at 75 million dollars each are a bargain for what they accomplished.

But with the war ended, it is time to ask ourselves an old question, which I have placed before readers on a number of occasions in the last decade: When will we be willing to spend the price of a battleship on the conquest of cancer?

In his report to President Truman on postwar scientific research, Dr. Vannevar Bush proposes a program of medical research that is big but still would cost us less than a new battleship a year.

He would begin the program of medical research for the nation with an appropriation of five million dollars a year, stepping this up to about 20 million dollars a year in time.

His feeling is that such research would best be carried on in the medical schools and research institutions now in existence and that appropriation of money ought not to be more rapid than the possibilities of putting it to work.

In other words, money by itself does not bring results. The money is effective only to the extent that trained scientists are on hand to utilize the funds.

As President Roosevelt observed when he asked Dr. Bush to undertake the present report last November, one or two diseases cause more deaths a year in America than have been suffered by this nation in World War II.

Heading the list of killers in America is the group of diseases resulting from high blood pressure and hardening of the arteries, namely, heart disease, and cerebral hemorrhage. This group causes one-third of all the deaths in America.

In 1940, there were 536,745 deaths from diseases of the heart and arteries. The amount spent on research in this field in 1940 was \$94,000 or 17c per death.

This situation would be dealt with by the recommendations proposed by Dr. Bush. He proposes, however, that the researches be carried on in existing institutions rather than in new Government laboratories.

"The primary place for medical research is in the medical schools and universities," he writes in his report. "In some cases coordinated direct attack on special problems may be made by teams of investigators, supplementing similar attacks carried on by the Army, Navy, Public Health Service and other organizations.

"Apart from teaching, however, the primary obligation of the medical schools and universities is to continue the traditional functions of such institutions, namely, to provide the individual worker with an opportunity for free, untrammelled study of nature, in the directions and by the methods suggested by his interests, curiosity and imagination. The history of medical science teaches clearly the supreme importance of affording the prepared mind complete freedom for the exercise of initiative."—David Dietz, in *San Francisco News*.

Henry David Thoreau (1817-1862).—Thoreau made pencils and taught school for a living. He was a friend of Emerson and a member of the famous Concord circle. His reputation as a naturalist rests on his immortal "Walden." Undoubtedly, if he had spent less time outdoors, he would have succumbed sooner to the tuberculosis to which he was subject. While counting growth rings on old tree stumps during a wet snow storm, he contracted a chill and the tuberculosis became active. In a vain effort to regain health, he went to Minnesota, but died in his forty-sixth year.—Warner's *Calendar of Medical History*.

# CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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## OFFICIAL NOTICE

### COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

#### Minutes of the Three Hundred Twenty-eighth (328th) Meeting of the Council of the California Medical Association

The meeting was called to order in the Empire Room of the Hotel Fairmont in San Francisco, at 10:30 A.M., on Sunday, August 21, 1945.

#### 1. Roll Call:

Councilors Present: Philip K. Gilman, Chairman; Sam J. McClendon, E. Vincent Askey, Herbert A. Johnston, Jay J. Crane, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Lloyd E. Kindall, Frank A. MacDonald, John W. Green, Walter S. Cherry, Edwin L. Bruck, E. Earl Moody, Dewey R. Powell, Edward B. Dewey, and George H. Kress, Secretary.

Councilors Absent: Sidney J. Shipman.

Present by Invitation: L. A. Alesen, M.D., Vice-Speaker; Dwight H. Murray, M.D., Chairman, Committee on Public Policy and Legislation; Chester L. Cooley, M.D., Secretary-Treasurer, California Physicians' Service; J. Frank Doughty, M.D., Chairman, Special Committee to report on Association of American Physicians and Surgeons of Indiana; Mr. Fred Kraft, Assemblyman from San Diego; John Hunton, Executive Secretary; W. M. Bowman, Executive Director, California Physicians' Service; Hartley F. Peart, Legal Counsel; Howard Hassard, Associate Legal Counsel; Clem Whitaker, Public Relations Adviser; James J. Boyle, Chief of Washington Office of the United Public Health League; Ben H. Read, Secretary, California Public Health League; Stanley K. Cochems, Executive Secretary, Los Angeles County Medical Association; Rollen Waterson, Executive Secretary, Alameda County Medical Association; W. Glenn Ebersole, C.M.A. Special Representative.

#### 2. Minutes:

Minutes of the following meetings of the Council and Executive Committee were submitted and actions taken approved:

(a) Council Meeting (324th) held in Los Angeles, May 5, 1945. (Printed in C. & W. M., June, 1945, page 344.)

(b) Council Meeting (325th) held in Los Angeles, May 6, 1945. (Printed in C. & W. M., June, 1945, page 347.)

(c) Council Meeting (326th) held in Los Angeles, May 7, 1945. (Printed in C. & W. M., June, 1945, page 347.)

(d) Council Meeting (327th) held in Los Angeles, May 7, 1945. (Printed in C. & W. M., June, 1945, page 347.)

(e) Executive Committee Meeting (192nd) held in Los Angeles, May 7, 1945. (Printed in C. & W. M., June, 1945, page 348.)

(f) Executive Committee Meeting (193rd) (Telephone intercommunication with mail vote ratification). (Printed in C. & W. M., August, 1945, page 82.)

\* Reports referred to in the minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

† For complete roster of officers, see advertising pages 2, 4, and 6.

(g) Executive Committee Meeting (194th) (Telephone intercommunication with mail vote ratification).

(Printed in C. & W. M., August, 1945, page 82.)

Concerning the action taken at the 194th meeting of the C.M.A. Executive Committee, Chairman Gilman gave the reasons why it seemed desirable to cooperate with neighboring constituent state medical associations in order to further the promotion of California Physicians' Service and of principles which had received approval by the C.M.A.

(h) "Trustees of C.M.A." Meeting (17th) held in Los Angeles, May 7, 1945. (Printed in C. & W. M., June, 1945, page 348.)

(i) Directors of "Trustees of C.M.A." Meeting (41st) held in Los Angeles, May 7, 1945.

(Printed in C. & W. M., June, 1945, page 348.)

### 3. Membership:

(a) A report of the membership as of August 11, 1945, was submitted and placed on file. The membership roster showed distribution as follows:

Total members (civilian and military) listed for year 1945: 7,790.

Total members in military service: 2,252.

(b) On motion made and seconded, it was voted to reinstate 90 members whose 1945 dues had been paid subsequent to the last meeting of the Council on May 7, 1945.

(c) On motion made and seconded, Retired Membership was granted to the following members, whose applications had been received in accredited form from their county societies:

Charles Morton Hosmer, San Diego County,  
Barney E. Coleman, Los Angeles County,  
J. F. Garrison, Los Angeles County.

### 4. Financial:

(a) A cash report as of August 11, 1945, was submitted.

In the discussion of the cash report, reference was made to the moneys in the Benevolence Fund. Councilor Anderson called attention to the fact that the Benevolence Fund had been increased in considerable amount through donations from the Woman's Auxiliary to the California Medical Association. It was voted that a letter be sent to the Woman's Auxiliary expressing appreciation for the generous donations that have been made to the Benevolence Fund.

(b) Report was made concerning income and expenditures for July and for seven months, ending on July 31, 1945.

(c) A balance sheet, as of July 31, 1945, was submitted.

On motion made and seconded, the above reports were received and placed on file.

### 5. Interim Appointments:

The following interim appointments made by the Council Chairman since the last meeting of the Council on May 7, 1945, were approved:

(a) Alvin G. Foord, Pasadena, appointed a member of the Professional Advisory Committee to the Bureau of Vocational Rehabilitation.

(b) William G. Donald, Berkeley, appointed a member of the C.P.S. Study Committee, vice H. J. Templeton, Oakland, resigned.

### 6. A.M.A. Meeting in San Francisco in 1948:

Discussion was had concerning the meeting of the American Medical Association which, by vote of the A.M.A. House of Delegates, is scheduled to be held in San Francisco some time during the year 1946. Because of war and transportation conditions, it was deemed advisable to give instructions to the C.M.A. delegates who

would represent the California Medical Association at the next meeting of the House of Delegates of the American Medical Association.

On motion made and seconded, the following resolution, to be sent to the Trustees of the American Medical Association and to the House of Delegates of the American Medical Association, was approved:

Resolution re: Meeting of American Medical Association in San Francisco

WHEREAS, The House of Delegates of the American Medical Association in previous annual sessions voted to hold an annual session of the American Medical Association in San Francisco in the year 1943, that decision, because of transportation difficulties incident to World War II, being changed by the A.M.A. Trustees; and

WHEREAS, The A.M.A. House of Delegates subsequently voted that the 1946 annual session of the American Medical Association should be held in San Francisco; and

WHEREAS, Existing transportation difficulties, if war continues, make it more than probable that the A.M.A. Trustees may again be called upon to waive the said decision for the A.M.A. meeting in San Francisco in 1946; and

WHEREAS, The 1947 meeting of the American Medical Association will be held in Atlantic City, the year 1947 being the 100th anniversary of the founding of the American Medical Association; and

WHEREAS, It would be proper that the twice-made decision of the House of Delegates to hold an annual session of the American Medical Association in San Francisco be reaffirmed; now therefore be it

*Resolved*, That the Council of the California Medical Association respectively petitions the Trustees of the American Medical Association and the House of Delegates of the American Medical Association to vote to hold the 1948 annual session of the American Medical Association in the City of San Francisco, (if continuation of World War II makes a meeting in San Francisco impossible); and be it further

*Resolved*, That copies of these resolutions be sent to the Secretary of the American Medical Association for transmittal respectively to the Trustees of the A.M.A. and the House of Delegates of the A.M.A.; and be it further

*Resolved*, That the eight delegates representing the California Medical Association in the House of Delegates of the American Medical Association be instructed to make the proper presentation to the A.M.A. Trustees and to the A.M.A. House of Delegates.

(b) Doctor Dwight H. Murray, Chairman of the Committee on Public Policy and Legislation, referred to the meeting held some months ago in Portland by the A.M.A. Council on Medical Service and Public Relations. He stated that it had been intended to have a meeting soon thereafter in California, but owing to the work incident to the legislative session, it had been postponed.

Upon motion made and seconded, it was voted to invite the A.M.A. Council on Medical Service and Public Relations to hold such a meeting in California in the near future.

### 7. Annual Dues for 1946:

A letter of June 15, 1945, from the Shasta-Trinity Medical Society was presented as follows:

"This Society disapproves of the House of Delegates in raising the annual dues of the California Medical Association to one hundred dollars for any or all of the reasons advanced by the Council whose recommendation it was."

It was voted that the Shasta-Trinity Medical Society be informed that the action taken was by the House of

Delegates of the California Medical Association which has supreme authority in such matters and that the Council was not in position to change the same.

#### 8. C.M.A. Committee to Report Re: Association of American Physicians and Surgeons:

The special committee appointed in accord with Resolution No. 4 (printed in C. & W. M., for June, 1945, on pages 328 and 340), presented at the C.M.A. Annual Session in May, 1945, to consider the objectives of the Association of American Physicians and Surgeons, made report. The committee consists of J. Frank Doughty, Tracy, Chairman; H. Gordon MacLean, Oakland; G. Dan Delprat, San Francisco; H. Randall Madeley, Vallejo; Samuel Ayres, Jr., Los Angeles; Eugene F. Hoffman, Los Angeles; K. C. Brandenburg, Long Beach; W. H. Geistweit, Jr., San Diego; H.M.F. Behneman, Healdsburg.

An oral statement was made by Doctor Doughty concerning the meetings that had been held by the committee. The report of the Special Committee is as follows:

"Re: Association of American Physicians and Surgeons

"The special committee appointed by the Speaker of the House of Delegates, unanimously adopted the following report which is presented herewith:

"In the opinion of this committee the objectives of the A.A.P.S. while highly commendable are capable of achievement by the California Medical Association without the necessity for additional organizational activity.

"Continuous diligence on the part of the California Medical Association in meeting the dangers of extraneous control of medical practice is urged."

Upon motion made and seconded, the Council voted to accept and approve the report as submitted.

#### 9. American Cancer Society:

Lyell C. Kinney, M.D., Chairman of the C.M.A. Cancer Commission submitted a report on correspondence and conferences with representatives of the American Cancer Society concerning cancer clinics, and other cancer activities in California. Attention was called to the House of Delegates resolution concerning cancer clinics (printed in C. & W. M., for June, 1945, on page 336).

Reports submitted by the Cancer Commission were approved as follows:

August 11, 1945.

The Council of the California Medical Association,  
Gentlemen:

Recent correspondence with the American Cancer Society has developed several important facts regarding the so-called "prevention clinics." The American Cancer Society has not formally approved any prevention clinic in California and has received no formal request for such approval. It is the policy of that Society not to approve any clinic unless it has the approval and supervision of the county medical society, or unless it is approved by the state executive committee. It is feasible now, if you so direct, that the executive committee shall be so formed that it reflects the will and judgment of this Council.

The American Cancer Society recognizes that many new clinics have been formed throughout the country that have no uniform or consistent policy and that there are no established standards for the operation of these clinics. In order to remove this confusion in its own policy, the American Cancer Society has referred the problem of clinics to a group of five well known and distinguished physicians. These are:

Dr. Frank E. Adair, Chairman  
Dr. Edwin P. Lehman  
Dr. John J. Morton  
Dr. Eugene P. Pendergrass  
Dr. Herman C. Pitts

In order to further clarify the situation, the American

Cancer Society has approached the Council on Medical Service and Public Relations of the American Medical Association, looking for advice and cooperation from the A.M.A. A committee consisting of Dr. Thomas A. McGoldrick and Dr. Louis H. Bauer, of New York, has been appointed to represent the A.M.A. in conferences with the American Cancer Society in this matter.

There is an additional factor in California that complicates the situation. The Donner Foundation of New York is intensively interested in "prevention clinics" and its representative has been in California encouraging the formation of such clinics and advising methods of procedure. This work of the Donner Foundation is independent of the American Cancer Society.

The Cancer Commission, at your direction, has surveyed the two clinics in California. The Commission, however, should not be expected to render a formal report until the American Cancer Society has developed its policy and until this policy has been approved by the A.M.A.

Respectfully submitted,

(Signed) LYELL C. KINNEY,  
Lyell C. Kinney, M.D., Chairman,  
Cancer Commission.

1 1 1

The President and the Council,  
California Medical Association.

Gentlemen:

The Cancer Commission looks forward to laying the groundwork of a cancer control program which can be further developed as soon as our members are released from military service. The proposed program is as follows:

1. A survey of the State to see what facilities are available for the diagnosis and treatment of cancer and what facilities are needed to cover the State.

2. To encourage county societies or groups of societies to sponsor and develop the necessary cancer clinics, preferably in approved general hospitals.

3. To encourage each clinic to make a consultative service available to all physicians in the county for their cancer patients irrespective of their financial status.

4. To promulgate standards for clinics in smaller communities not in a position for full approval by the American College of Surgeons.

5. To provide periodic consultation clinics in smaller communities by a visiting team when requested by the county medical society.

6. To organize a cancer committee in every county medical society to cooperate with the Field Army of the American Cancer Society and to supervise their activities.

7. To develop an educational program for physicians. This would include distribution of a cancer manual for office reference after the material and the method of distribution have been approved by the Council. Also, to arrange for postgraduate articles in the Cancer Commission column of CALIFORNIA AND WESTERN MEDICINE. Also, to cooperate with the committee on postgraduate activities of the C.M.A. to provide programs for county medical societies.

8. To develop a tumor registry, preferably under the control of the Cancer Commission or the State Department of Health.

9. If the Council will approve and direct the Cancer Commission to do so, the members of the Commission will form a majority of the Executive Committee of the California branch of the Field Army of the American Cancer Society.

If the members of the Cancer Commission are directed by the Council to function also on the Executive Committee of the Field Army, they will attempt to carry out

the "C.M.A. Formula for Organization of the Field Army in California." The following objectives of the Executive Committee are proposed:

1. That the entire cancer program in California shall be developed in coöperation with and under the supervision of the C.M.A. and the county societies.

2. To employ an executive secretary similar to that of the California Tuberculosis Association to assist the Commander of the Field Army in personal contacts with all county units.

3. To obtain proper publicity for and public support of approved cancer clinics.

4. To assist and direct the educational program of the Field Army and encourage county medical societies to do likewise.

5. To direct the expenditure of money raised in the annual campaign into the most effective channels for cancer control.

Suitable projects have been proposed for the expenditure of campaign money:

1. Distribution of educational literature.

2. Three or more local offices with clerical help and cancer information centers throughout the State.

3. An executive secretary.

4. Assist approved cancer clinics in financing clerical help, nursing or social service personnel as may be needed by these clinics.

5. Plan the transportation of patients to clinics or physicians.

6. Provide for the care of terminal cancer cases.

This is an extensive program which cannot be carried out without the support of the profession throughout the State. If the program is approved by the Council it is the intention of the Commission, in its dual capacity, to keep the State office of the C.M.A. constantly and fully informed of all developments. It is also the intention of the Commission to refer to the Council immediately any changes in policy or any project not fully covered by the above program. The Council is requested to criticize, revise, approve or disapprove the above program as they see fit. In addition, the Council is requested to authorize President Gilman, acting for the C.M.A., to nominate members for the Executive Committee of the California Field Army of the American Cancer Society.

Respectfully submitted,

(Signed) **LYELL C. KINNEY,**  
*Lyell C. Kinney, M.D., Chairman,*  
*Cancer Commission.*

#### 10. C.M.A. Advisory Planning Committee:

The C.M.A. Advisory Planning Committee, authorized by House of Delegates Resolution V at this year's Annual Session (June C. & W. M., pages 328 and 340), and consisting of Messrs. John Hunton, Executive Secretary of the California Medical Association; Howard Hassard, Associate Legal Counsel; Stanley K. Cochems, Executive Secretary, Los Angeles County Medical Association; Rollen Waterson, Executive Secretary, Alameda County Medical Association; Ben H. Read, Secretary, Public Health League of California; and W. Glenn Ebersole, Special Representative of the C.M.A. Council, submitted a report prepared at a meeting held on Saturday, August 11. Chairman John Hunton made oral comment on the recommendations submitted with Council action as follows:

- (a) The Committee recommended to the Council that the plan of campaign outlined by Mr. Whitaker at the 1945 Annual Session be instituted immediately and that Mr. Whitaker be employed to manage the campaign. Approved by the Council.

- (b) The Committee recommended that a series of public health meetings on medical topics of public interest

which the Los Angeles County Medical Association has planned be made available to all other county societies and that all county societies plan to hold simultaneous meetings on the same subjects. The Los Angeles County Medical Association will be glad to furnish release copies to other county society units. Approved.

- (c) The Committee recommended that several agreements reached by Doctors Gilman and Murray with officers of the Woman's Auxiliary be approved by the Council. These agreements referred to the monthly publication of "The Courier," a closer working arrangement between the Auxiliary and the C.M.A., the wider use of the Auxiliary in legislative activities and greater encouragement for the Auxiliary by the C.M.A. Approved.

- (d) The Committee recommended that the Council request all medical schools in California to institute a one-year required course in medical economics, instructors for which would be selected by the C.M.A. The Council voted to inquire of the medical schools on the feasibility of such courses.

- (e) The Committee recommended that each county medical society institute a course of indoctrination for membership applicants, to consist of at least six meetings and to cover the relationship of the individual physician with his fellows and his community. Approved.

- (f) The Committee submitted to the Council a suggested statement of "Principles of the C.M.A. on Health Insurance." After discussion and addition of one section covering medical education, this statement was approved as follows (these principles appeared in C. & W. M., for August, 1945, on page 60, in conjunction with the Principles adopted by the American Medical Association on June 22, 1945):

#### PRINCIPLES OF THE CALIFORNIA MEDICAL ASSOCIATION ON HEALTH INSURANCE\*

It is in the public interest that the California Medical Association, representing the doctors of medicine practicing their profession in the State of California, publicly make known the principles which should form the basis of any health insurance program, and from which there should be no material deviation if the public welfare is to be properly and adequately protected. The public health and good medical practice are inextricably interwoven and interdependent.

This statement is made with the understanding that the public is entitled to the best possible quality of medical service and access thereto. The medical profession must be in a position to render such service if the best interests of the public are to be served.

The manifold and constant advances in the science and practice of medicine are put to public benefit only when they can be utilized by an alert and progressive medical profession. The public is entitled to profit by all scientific advances and the public welfare demands that the medical profession have complete scientific freedom in their application.

Any sound health insurance program should fulfill each of the following basic points:

1. It is of primary importance that the people should be enabled to provide for the costs of illness on a regular budget basis during periods of good health and stable earning power, so that they may have medical-economic security. It is vital, however, that the distribution of costs should be undertaken in a manner which will still guarantee the finest possible medical care and which will prevent any deterioration in the quality of medical service.

2. To serve the ultimate public interest any health insurance plan must,

- a. Be voluntary and not compulsory in nature,

- b. Retain individual initiative in medical practice, so that the incentive for further advance in scientific medicine may continue,

- c. Fully protect the freedom of choice, both of the patient in choosing a physician and of the physician in choosing his community, type of practice and professional procedures,

- d. Offer medical care in coöperation with allied services against serious illness or injury,

\* For full page display of these principles, see CALIFORNIA AND WESTERN MEDICINE, for August, 1945, on p. 61.

e. Offer participation at a cost within the means of all employed persons and income-receiving families, and

f. Provide a fair reward to those rendering the service which will give continued stimulus to scientific medical development and sound medical practice.

3. The function of state governments should be to encourage voluntary health insurance programs but not regiment the patient and the medical profession or operate compulsory health insurance plans established by political means; to further this function, the state should cooperate with medical and allied professional groups to provide the availability of medical and associated care through acceptable prepayment plans in areas where a shortage of medical and hospital facilities exists.

4. It is in the public interest that the human factor in medical care be thoroughly recognized; the sanctity of the patient-physician relationship must be maintained and the method of providing medical care must not become enmeshed in bureaucratic red tape and a system of tickets, coupons, questionnaires and other political controls and delays.

5. It is essential for the public welfare that there exist in each state a complete inventory of all medical resources and existing facilities. It is in the public interest that a coherent and comprehensive educational program be undertaken, preferably by responsible authorities and the medical profession in a coordinated effort, to advise all the people of the state on the facilities and services available to them in the event of need and to encourage sound public health measures for the prevention of both accidental and non-accidental illnesses and injuries.

6. There should be a coordinated program on the part of all groups concerned with this problem, directed to the extension of voluntary health insurance plans, so that our people may systematically provide for their health care on a budget basis.

7. Any plan of health insurance must make provision for the maintenance of a high standard of medical education.

#### 11. Special Committee on Prepayment Plans and C.P.S.:

The Special Committee on Prepayment Plans and C.P.S., through its chairman, Loren R. Chandler, reported that this committee had had only one organization meeting but had in contemplation two meetings in the near future, after which a report would be submitted in due course to the C.M.A. Council. (Reference to this committee was made in CALIFORNIA AND WESTERN MEDICINE, for June, 1945, on page 347, under Item 5.)

#### 12. Committee on Public Policy and Legislation:

(a) For the C.M.A. Committee on Public Policy and Legislation, and the work carried on at this year's biennial session of the California Legislature, report was made by the committee chairman, Dwight H. Murray, who, on behalf of his committee, desired to express appreciation for the services rendered by physicians throughout the State, with special thanks to the members of the profession resident in Sacramento and to State Association officers and others who made repeated trips to the Capitol.

Doctor Murray also spoke of the recent meeting in Denver called at the instance of the Michigan State Medical Society on June 28-29, 1945, at which some seventeen states were represented. The problems in Michigan are similar in some respects to those in California. It was there agreed voluntary plans of medical and hospital care should be promoted. It was also agreed that the better organized state medical associations have an obligation to cooperate and give aid in these matters to smaller constituent state medical units needing such help.

(b) Informal discussion was had concerning prospective legislation which might be submitted to Congress through certain Senators.

(c) The extent to which the California Medical Association should give financial cooperation to the United Public Health League was also discussed. The initial appropriation was authorized on January 23, 1944, by the Council for approximately \$18,000, the same being on the basis of \$3.00 for every C.M.A. member paying dues.

After discussion, it was agreed that the \$3.00 allocation

for each member who is paying dues should be again authorized.

In connection with the work of the United Public Health League, Mr. James J. Boyle, Washington representative of the United Public Health League, was called on to make report.

(d) Mr. Fred Kraft, Assemblyman from San Diego, had been invited to be present, and made a short address concerning the problems that had come up during this year's legislative session in connection with proposed statutes having relation to medical care. Mr. Kraft stressed the importance of a campaign of education through which citizens everywhere would be able to obtain the proper orientation of the extent and significance of medical care and other issues involved.

(e) Mr. Clem Whitaker, who has been carrying on public relations work for the California Medical Association during the last year, was also called upon for comment. He outlined his observations of what had taken place and indicated what he thought was ahead.

(f) Mr. Ben Read, Secretary of the Public Health League of California, also made comment concerning this year's legislative battles.

#### 13. Legal Department:

(a) Mr. Peart called attention to the fact that the *Surcharge Order* granting a 15 per cent increase in fees over the present Industrial Accident Commission fee schedule would terminate by its terms at the expiration of six months after the duration, and suggested that a new application be filed during this six-month period. The attorney pointed out that under the act passed at the last Legislature, the Industrial Accident Commission had been reorganized and the Commission would now consist of five members; that the terms of two of the present Board of three had already expired. Furthermore, that the Assembly had appointed an interim committee on the subject of insurance with express provision made for an examination and report in the matter of medical fees in compensation cases.

The attorney further reported that Pacific Employers Insurance Company had refused to add the amount of the surcharge to a bill rendered by Dr. Allan L. Bramkamp of Banning, which surcharge amounted to the sum \$1.14. Dr. Bramkamp referred the matter to the legal department; that he had promptly prepared a petition for the allowance of the surcharge and had returned its check to the insurance company advising it of the doctor's intention to petition for the correct amount of his bill, and that the insurance company had thereupon paid the bill in full.

After discussion, on motion duly seconded and unanimously adopted, the present committee was instructed to proceed with a new application, at such time as it seemed advisable, said committee consisting of Dr. Gilman, Mr. Hunton, and Mr. Peart.

Mr. Peart further suggested that the proposed fee schedule should be again submitted to the fee schedule committee for final check and approval.

(b) Concerning *Sales Tax on Roentgenograms*, the General Counsel reported that the State Board of Equalization had interpreted Rule 23 of the Board to include a sales tax on the furnishing of Roentgenograms, termed in the rule "x-ray pictures." The position of the Board appeared to be that as lay laboratories had been held to be retailers and subject to the tax, in order to avoid discrimination it was deemed necessary to classify professional laboratories likewise as retailers.

Acting under the direction of the Executive Committee, the Legal Department submitted briefs and authorities to the counsel for the State Board of Equalization and obtained a ruling that the tax would apply to the fair retail

value of x-ray pictures or negatives only where there is an actual sale, that is transfer of title by the producers thereof, and that if the producer retains ownership of the pictures or negatives he is the consumer of the film and other materials used in their production, and the tax is therefore applicable to the sale of such materials to him.

Mr. Peart stated that an opinion based upon this ruling had been disseminated among the members specializing in Roentgenology, but that in view of an erroneous article appearing in the *Journal of the American Medical Association*, Mr. Hunton had prepared an additional article for publication in *CALIFORNIA AND WESTERN MEDICINE*, so that all members of the Association would be fully advised of the State Board's interpretation of the rule and of the governing facts.

#### 14. House of Delegates Resolution No. 6:

House of Delegates Resolution No. 6, presented at this year's Annual Session, and appearing in the June, 1945, C. & W. M., on pages 329 and 342, was referred to in a letter received from Mr. James A. Vincent of the Christian Science Committee on Publications for Northern California.

It was voted that the communication be placed in the files.

#### 15. C.M.A. Physicians' Benevolence Committee:

(a) *C.M.A. Benevolence Fund*.—Councilor Axel E. Anderson, Chairman of the C.M.A. Physicians' Benevolence Committee, made report concerning the work of the committee, with special reference to the conditions in Los Angeles County, where some 93 individuals receive aid, more than one-half being widows of physicians. In Los Angeles, with the aid of the Los Angeles County Medical Association, the monthly outlay is something like \$800. After discussion, the Council voted to approve the committee's recommendation that the allocation to Los Angeles County from the C.M.A. Benevolence Fund be increased from \$300 to \$500 per month.

(b) *Physicians' Aid Association of Los Angeles County Medical Association*.—Chairman Anderson also called attention to the campaign which had been inaugurated by the Los Angeles County Medical Association to build up an independent Benevolence Fund, stating that to date in that county the sum of \$150,000.00 had been secured for such objective, the campaign to raise a fund of \$500,000.00 for that county still going on.

#### 16. Proposal for a Special Committee on Nutrition:

Concerning letters and proposals submitted by Francis M. Pottenger, Jr., of Los Angeles County, in re: a special committee on Nutrition, Council Chairman Gilman stated that he had taken up the matter with Vice-Speaker Aleson and that the subject would be referred to Mr. Clem Whitaker for consideration. The Council Chairman's action was approved.

#### 17. Sickness Insurance Legislation and Principles:

Reference was made to the platform adopted by the A.M.A. Council on Medical Service and Public Relations and adopted by the Board of Trustees of the American Medical Association on June 22, 1945.

The Editor stated that this platform would appear in the August, 1945, issue of C. & W. M., on page 61, and that the C.M.A. Principles on Health Insurance, as adopted by the Council at this present meeting, would also be printed in conjunction therewith.

#### 18. Communication from Foote, Cone and Belding:

A communication from Foote, Cone and Belding concerning a public educational program was referred by the Council to Mr. Clem Whitaker for consideration and report to the Council Chairman.

#### 19. Time and Place of Next Meeting:

In accordance with past custom, the next meeting of

the Council will be held in Los Angeles some time during the fall, the time and place to be decided by the Council Chairman.

#### 20. Executive Session:

The Council went into Executive Session.

(a) *Employment of Public Relations Representative*.—Discussion was had concerning the importance of an active educational campaign with special reference to proposed legislation dealing with compulsory and voluntary medical care plans. After discussion, it was voted that Mr. Clem Whitaker of San Francisco be employed and that the C.M.A. Executive Committee be authorized to make the necessary arrangements in regard to term of employment and financial remuneration.

(b) *Employment of Special Council Representative*.—Council Chairman Gilman stated that Mr. Glenn Ebersole had been making a first-hand investigation of medical care and hospitalization plans in different States in the Union in order that proper report could be made thereon.

Concerning terms of employment of Mr. Ebersole, it was agreed that this should be at the discretion of the Chairman of the Council.

(c) *Clearing Officer*.—It was agreed that the plan in use during the last session of the Legislature whereby the Executive Secretary, John Hunton, would be the clearing officer for legislative publicity, etc., should be continued.

(d) *Educational Campaign Under Auspices of C.M.A. Committee on Public Policy and Legislation*.—Full discussion took place concerning the work of the C.M.A. Committee on Public Policy and Legislation, its responsibilities and future activities.

It was voted that the sum of \$10,000 be allocated for use by the Committee on Public Policy and Legislation as conditions would warrant drafts thereon.

(e) *Honorable Retirement of the Secretary-Editor*.—The many years of service given by Dr. George H. Kress, Secretary-Editor of the California Medical Association, was called to the attention of the Council by Chairman Gilman.

After discussion it was unanimously voted that the Secretary-Editor would be granted honorable retirement immediately following the 1946 Annual Session, such retirement to be accompanied by the payment of a suitable life pension in an amount to be determined by the Executive Committee and in keeping with the value of the services rendered by the Secretary-Editor over a long period of years.

Mention was made that a history of the California Medical Association, now in its seventy-fifth year, had never been written. Also, that the retiring Secretary-Editor had had in mind the collection of historical data that would make possible the production of a history of the California Medical Association. Councilors expressed themselves as believing such a plan should be developed.

(Note. The above minute concerning the Secretary-Editor submitted by Dr. Philip K. Gilman.)

#### 21. Adjournment:

There being no further business, on motion made and seconded, it was voted to adjourn.

PHILIP K. GILMAN, M.D., *Chairman*,  
GEORGE H. KRESS, M.D., *Secretary*.

Amidst the calamities which war has brought on our country this one benefit has accrued—that our eyes are withdrawn from England, withdrawn from France, and look homeward. We have come to feel that "by ourselves our safety may be bought."

—Emerson, *Letters and Social Aims: Social Aims*.

# EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION

## *Minutes of the One Hundred Ninety-fifth (195th) Meeting of the Executive Committee of the California Medical Association*

The 195th meeting of the C.M.A. Executive Committee was held in San Francisco on September 26, 1945, at 6:30 P.M.

### 1. Roll Call:

Members Present: John W. Cline, Executive Committee Chairman; Philip K. Gilman, Council Chairman; Sam J. McClendon, President-Elect; E. Vincent Askey, House of Delegates Speaker; and George H. Kress, Secretary.

Present by Invitation: John Hunton, Executive Secretary; and Howard Hassard, Associate Legal Council.

### 2. Communication from the Blue Cross Committee of the Association of California Hospitals:

The special subject for discussion was a communication received from George U. Wood, Chairman of the Blue Cross Committee of the Association of California Hospitals, the same referring to plans related to voluntary prepayment medical and hospital activities, with suggestions concerning certain features thereof.

The objectives proposed and the individual items were given extensive discussion and careful consideration.

The conclusion finally reached was that a reply should be sent to the Blue Cross Committee of the Association of California Hospitals, informing the Association of California Hospitals that the Executive Committee of the California Medical Association was in favor of the proposal to mutually develop a uniform plan for the State of California concerning voluntary prepayment medical and hospital service plans and that if the Association of California Hospitals will carry through their proposal concerning hospitalization procedures in relation thereto, it was felt the California Medical Association would be happy to confer further concerning details. Also, that thanks be expressed to the Association of California Hospitals and its Blue Cross Committee for this follow-up expression of earlier joint conferences with the C.M.A. in relation to the problems at issue.

Upon motion made and seconded, it was so voted, and it was agreed that a communication in line with the above should be formulated and sent to the Association of California Hospitals and its Blue Cross Committee, of which George U. Wood is chairman. (See also p. 156.)

### 3. Dues of Military Members:

Informal comment was made concerning state association dues of military members and it was agreed that this item should be placed in the agenda of the Council meeting to be held on October 21, 1945, in Los Angeles.

### 4. Adjournment:

There being no further business, it was voted to adjourn.

JOHN W. CLINE, M.D., *Chairman*  
GEORGE H. KRESS, M.D., *Secretary*

### A.M.A. House of Delegates to Convene in Chicago on December 3, 1945

The annual meeting of the House of Delegates, the policy-making body of the American Medical Association, will be held in Chicago for four days, beginning December 3, 1945.

The annual session, usually held in June, but delayed this year because of wartime travel restrictions, was called by Herman L. Kretschmer, M.D., Chicago, President of the A.M.A., and H. H. Shoulders, M.D., Nashville, Tenn., Speaker of the House of Delegates. The meeting, which will be held in the Palmer House, is ex-

pected to bring together approximately 200 delegates and officials of the Association, coming from all parts of the country.

During the session, Dr. Kretschmer will relinquish the presidency of the Association and will be succeeded by Roger Irving Lee, M.D., of Boston, who was chosen president-elect at the wartime session of the A.M.A., which was held in Chicago in June, 1944.

The December session of the House of Delegates will be devoted to consideration of many problems of great significance for the future of medical practice. Many questions related to medical services and policies for the medical profession will be presented. Maintenance of a high quality of medical service, a high standard of medical education, and a wider distribution of good medical care to all the people are among the topics to be considered.

Because of the war, the annual A.M.A. convention could not be held in New York this year. A wartime session, attended by more than 7,000, was held in Chicago last year. San Francisco was selected some years ago to play host to the 1946 convention.

At a meeting of the A.M.A. Board of Trustees held in September, 1945, it was deemed advisable to recommend that the 1946 A.M.A. be held during July or August, on dates to be selected later.

### C.M.A. Council Meeting in Los Angeles

A meeting of the Council of the California Medical Association will be held in Los Angeles on Sunday, October 21 (in Conference Room, Hotel Biltmore, at 10:00 A.M.).

### C.M.A. Committee on Prepaid Medical and Hospital Care

At the House of Delegates meeting of the California Medical Association held in Los Angeles on May 7, 1945, the chairman of the Council was instructed to appoint a State-wide representative committee to study the work of prepaid medical and hospital plans and procedures in California including California Physicians' Service, the committee so appointed to report at meetings of the Council and submit recommendations to the next House of Delegates meeting.

The Chairman of the Council has appointed the following committee: Doctors L. R. Chandler, chairman, H. E. Henderson, Sidney J. Shipman, Jay J. Crane, Samuel Ayres, Jr., Peter Blong, J. E. Young, M. A. Hopkins, A. E. Moore, William Donald and A. M. Meads.

This committee held its organization meeting on Sunday, July 15, 1945, and the following purposes and duties of the committee were defined: (1) To study California Physicians' Service and other prepaid medical and hospital care plans, both voluntary and compulsory, (2) To make periodic reports to the Council of the California Medical Association, (3) To make such recommendations concerning the subject of study as the committee may consider advisable to the House of Delegates of the C.M.A. at its next regular meeting. It was agreed and understood that committee reports or parts thereof submitted to the Council may be published for the interest of the medical profession in CALIFORNIA AND WESTERN MEDICINE when so requested by this committee.

The committee will welcome constructive suggestions in connection with its study as outlined above. The committee will also welcome a report of any experiences physicians may have had with prepaid medical care in order to aid it in reaching conclusions and making recommendations, both to the Council during the year, and the House of Delegates at its next meeting.

## COUNTY SOCIETIES†

### CHANGES IN MEMBERSHIP

#### New Members (14)

##### Alameda County (1)

Buckingham, Dewitt A., *Oakland*

##### Fresno County (2)

Buel, Walter H., *Alhambra*

Montgomery, John R., *Fresno*

##### Los Angeles County (1)

Sekiyama, Isami, *Los Angeles*

##### Orange County (1)

Wehrly, Mildred, *Santa Ana*

##### San Diego County (2)

McSparran, Joseph L., *San Diego*

Murrill, William A., *San Diego*

##### San Francisco County (6)

Armanino, Louis Peter, Jr., *Stockton*

Baum, Max, *San Francisco*

Fehrer, George Schubert, *San Francisco*

Petit, Donald William, *Randolph Field, Texas*

Schwab, Otto B., *San Francisco*

Sehring, Maxine Moore, *San Francisco*

##### San Mateo County (1)

Gaard, Genevieve, *San Carlos*

#### Transfers (1)

Gray, Claude C., from *San Francisco County* to *Sacramento County*

## In Memoriam

**Aland, Albert Harold.** Died at West Los Angeles, July 24, 1945, age 57. Graduate of Western Reserve University School of Medicine, Cleveland, Ohio, 1916. Licensed in California in 1944. Doctor Aland was a member of Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

**Allan, James T. M.** Died at Los Angeles, August 26, 1945, age 75. Graduate of the University of Southern California School of Medicine, Los Angeles, 1903. Licensed in California in 1903. Doctor Allan was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

**Axline, Joseph T.** Died at North Hollywood, August 14, 1945, age 63. Graduate of St. Louis University School of Medicine, Missouri, 1906. Licensed in California in 1922. Doctor Axline was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

**Babcock, Edward Saunders, Jr.** Died at Sacramento, September 3, 1945, age 47. Graduate of the University of California Medical School, Berkeley-San Francisco, 1923. Licensed in California in 1923. Doctor Babcock was a member of the Sacramento Society for Medi-

cal Improvement, the California Medical Association, and a Fellow of the American Medical Association.

**Davis, William Dewey.** (Captain, United States Army.) Killed on the USS Comfort, April 28, 1945, age 32. Graduate of the University of Chicago, the School of Medicine, Illinois, 1939. Licensed in California in 1940. Doctor Davis was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

**Fairchild, Chester Hyman.** Died at Woodland, September 6, 1945, age 75. Graduate of Cooper Medical College, San Francisco, 1906. Licensed in California in 1906. Doctor Fairchild was a Retired Member of the Yolo County Medical Association, and the California Medical Association.

**Holzman Albert Joseph.** Died at Santa Barbara, August 21, 1945, age 51. Graduate of Rush Medical College, Illinois, 1929. Licensed in California in 1929. Doctor Holzman was a member of the Santa Barbara County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

**Keltz, Charles.** (Captain, United States Army.) Killed in action, October 24, 1944, place of death unknown, age 37. Graduate of the University of Southern California School of Medicine, Los Angeles, 1929. Licensed in California in 1933. Doctor Keltz was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

**McKee, Albert Brown.** Died at San Francisco, August 19, 1945, age 83. Graduate of the Cooper Medical College, San Francisco, 1886. Licensed in California in 1886. Doctor McKee was a Retired Member of the San Francisco County Medical Association, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

**Neumann, Ernst Valentine.** Died at Hollywood, August 14, 1945, age 65. Graduate of Creighton University School of Medicine, Omaha, Nebraska, 1913. Licensed in California in 1926. Doctor Neumann was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

**Rogers, Henry Stanley.** Died at Finley (Lake County), September 14, 1945, age 61. Graduate of Creighton University School of Medicine, Omaha, Nebraska, 1915. Licensed in California in 1917. Doctor Rogers was a member of the Sonoma County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

**Van Meter, Fletcher Jackson.** Died at Yucaipa, August 4, 1945, age 62. Graduate of Drake University College of Medicine, Des Moines, Iowa, 1906. Licensed in California in 1926. Doctor Van Meter was a member of the Mendocino-Lake County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

†For roster of officers of component county medical societies, see page 4 in front advertising section.

**Young, Dwight Dunham.** (Commander, United States Navy). Died May, 1945, place of death unknown, age 43. Graduate of Columbia University College of Physicians and Surgeons, New York, 1928. Licensed in California in 1929. Doctor Young was a member of the Orange County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

## COMMITTEE ON ORGANIZATION AND MEMBERSHIP

### San Francisco County Medical Society Plans New Home

*Following item appeared in October Bulletin of the  
San Francisco County Medical Society*

In the near future the County Society will vote upon certain plans regarding its Washington Street headquarters of the San Francisco County Medical Society. In this connection the following facts are submitted to the membership in an open letter by the president:

Dear Doctor:

The present period of postwar reconversion presents an excellent opportunity to take stock of the physical equipment and properties of the San Francisco County Medical Society.

At the present time we have on our rolls a paying membership of 823 and an additional 406 members serving in the armed forces. An increasing number of these men and women are now returning to private practice.

We also own clear the property at 2180 Washington Street. We possess a library in this building and have a vested interest in the Irwin Memorial Blood Bank. We have in addition a moderate sum of money in the bank and have built up a considerable fund for the use of returning war veterans to help them become reestablished in private practice.

We recently have acquired the services of a full-time executive secretary, Mr. Frank J. Kihm, whose duties will be to extend many of the present activities of the County Society of a business and organizational nature.

*The Building at 2180 Washington Street.* This building, as you know, was originally erected as a private mansion by one of the early California millionaires and is an exceedingly ornate building beautifully finished within and without. It is now close to 50 years of age. Its exterior is deteriorating rapidly and the interior is in constant need of repairs, particularly in regard to plumbing.

Taxes to the City and County of San Francisco amount to \$5,300 annually.

The building was acquired by the San Francisco County Medical Society late in the year 1926. It may be concluded that the building as it now stands will never again be utilized as a private residence. On the other hand, it is ill-adapted to the particular needs of a scientific society such as the San Francisco County Medical Society. The Society needs for its purposes a properly ventilated lecture hall with suitable acoustics and relatively small space for the maintenance of its records, files, and a meeting place for smaller groups such as the directors, and little beyond that.

The question now arises, since the building is paid for and the County dues will be quite high—what would be the best disposition to make of the present property? Should it continue to be used in its present form with the limitations that it obviously presents; should it be remodeled to fit the requirements of the Society; or should it be disposed of? Another alternative would be

to dispose of the building and upper half of the lot and construct more suitable quarters on the lower section fronting Jackson Street.

The building as it stands, while a Class A building, is not desired by any real estate brokers and would undoubtedly be torn down, and at considerable expense. The lot on which the building stands in its present zoning is worth about \$75,000. If we were able to have the district rezoned to permit an apartment house building, we could probably expect \$150,000 for the lot and nothing for the building.

*The Library.* While the library of the Society contains approximately 15,000 volumes, many of these are in the form of obsolete textbooks. These books are of little value. We do possess a number of important files of periodicals which are in good condition. The library as such is rarely used by the members and should members require a library study of any particular subject, undoubtedly the facilities of the two university libraries containing many more complete periodical files are much more desirable. The Board of Directors has considered and in fact authorized the disposal of the present County Society library and a committee composed of Drs. F. L. Reichert, L. R. Chandler, M. W. Debenham, M. L. Montgomery and C. D. Horner is to study the matter. As yet no report has been received. It would seem that there is little need for the County Society's attempting to maintain a medical library in a city in which the two best libraries on the Coast are already situated.

*Meeting Hall.* The matter under consideration by the Board of Directors is whether one of the two following plans would or would not be desirable: (1) After the disposal of the present property, should this be possible, to sign a long-term lease in some building, the construction of which is now contemplated by others, for quarters which would be specifically constructed in accordance with the requirements of the County Society including suitable auditorium, suitable small meeting places and suitable quarters for our office staff, or (2) whether property should be acquired in some reasonably centralized area, although not downtown, where the ground space would not be excessively expensive and where parking facilities would be available, and there construct a one-story building for the special purposes of the Society.

It should be emphasized in connection with the first option (leasing space in a new downtown office building) that rentals for adequate space would be extremely high and out of line with the Society's revenues. For this reason the Board of Directors seriously questions its feasibility.

The future disposition of the Irwin Memorial Blood Bank does not conflict with the above plans since suitable arrangements can be worked out for this department without a great deal of difficulty.

The attention of the membership is earnestly requested on the above subject, and it is hoped that as many as possible will express their views on ballot-forms to be sent out shortly so that the Board of Directors may be guided in its future deliberations.

Yours very truly,

G. DAN DELPRAT, M.D., *President.*

When honored and decrepit age shall lean against the base of this monument, and troops of ingenious youth shall be gathered round it, and when the one shall speak to the other of its objects, the purposes of its construction, and the great and glorious events with which it is connected, there shall rise from every youthful breast the ejaculation, "Thank God, I—I also—am an American!"

—Daniel Webster, *Address*, Charlestown, Mass., 17 June, 1843, at completion of the Bunker Hill Monument.

### Alameda County Medical Association

#### *President's Message—The Problem of C.P.S. and Unity in California Medicine*

For several years the Alameda County Medical Association has been officially critical of several features of California Physicians' Service. In the first place, we have felt that its "service" plan, under which physicians are paid by "units," was actuarially and economically unsound and that it constituted a form of agency control, even though set up by our own fellow physicians.

That our repeated criticisms have been constructive and worthwhile is evidenced by several improvements which have been made in the management and business procedures of the organization. Full coverage policies have been eliminated, and experienced business men have been hired to manage the business. It is admitted that these changes have been at least partly brought about as a result of the efforts of the Alameda County physicians.

So far, so good.

However, our constructive criticism of C.P.S. and our attempts to change it to the indemnification plan of insurance have not been productive of good feeling between our county and our state organizations. A lack of unity has resulted, the blame for which cannot be said to rest entirely on the shoulders of either organization.

No thinking man could possibly have observed the happenings throughout the world within the last decade without realizing that a great force of leftism is threatening society in general, and medicine in particular. We do not need to rely upon the statement of the officers of C.M.A. that we and the public are imminently facing the dangers and evils of compulsory health insurance. We have recently seen such measures defeated by a narrow margin in our Legislature, and we have, at the moment, information that the proponents of these schemes, formerly divided in their attacks, are now teaming up to put over their ideas. In order to defeat them, we must have coöperation between the liberal and sound citizens of the State, business organizations, insurance companies and the medical profession. To coöperate effectively with allies, who have come to our assistance in our own battle for professional freedom, we must have unity within our own ranks.

The Alameda County Medical Association sincerely believes that the best way to obtain such unity would be to convert C.P.S. to indemnity, a form of voluntary health insurance which every doctor of California could honestly and enthusiastically sell to his patients. At the last meeting of the House of Delegates, we secured the appointment of an impartial committee, headed by Dr. L. R. Chandler, to study this problem. This committee must report its findings and recommendations to the next meeting of the House of Delegates.

Inasmuch as a compulsory health insurance bill probably will be introduced at an early session of the Legislature, it is important that Dr. Chandler's committee and the House of Delegates act as soon as possible. Following the presentation to the physicians of California of the information gathered by this committee, for their study and evaluation, it would be a simple matter to conduct a plebiscite by mail of all members of the California Medical Association, asking them to state their preference for either an indemnity plan or a service plan in C.P.S. as a guide to the action of the House of Delegates. I have personally suggested this to the officers of the C.M.A.

My suggestion of a plebiscite is made with a full understanding of both my privileges and responsibilities as a member of a democratic organization. My democratic *privilege* is to express myself upon any question, to attempt to induce others to accept my viewpoint, to be

heard either directly or by representation, and then to have a vote. My *responsibility* is to bow to and support the will of the majority if the vote does not favor my opinion. But it is also my privilege to again present my views at the next opportunity and, if I am then successful in influencing a majority, it will be the responsibility of those who once disagreed with me to support my opinion or my plan.

Therefore, after we of Alameda County have done our best to convince the doctors of California of the value of the indemnity plan, after Dr. Chandler's committee has studied its merits, after a plebiscite has been held and after the House of Delegates has given it a fair hearing, I feel that the Alameda County Medical Association, as members of a democratic organization, should support the action of the majority of the House of Delegates.

In the meanwhile, until we are satisfied regarding what the majority of the physicians of California want done with C.P.S., the big issue is voluntary as against compulsory health insurance. And we of Alameda County should be selling the fundamental American concepts and the advantages of voluntary insurance to our patients. As individuals, we may sell the *type* of voluntary plan in which we believe—Blue Cross, commercial plans, or C.P.S.—but we must sell *voluntary* insurance.

In brief, I feel that the greatest danger that threatens the health of the public and the practice of medicine is compulsory health insurance, and that it is wise for us to make every effort to gain unity in our own ranks in order to bring our full potential strength into the coming struggle with the now unified and united proponents of this greater evil.—Dr. Harry J. Templeton's message in October "*Bulletin*" of Alameda County Medical Association.

### Los Angeles County Medical Association

#### *"The State of the Association"*

In *The Bulletin* of the Los Angeles County Medical Association, issue of September 20, appears an editorial by the Association Secretary, Doctor E. T. Remmen, under the caption, "The State of the Association." Secretary Remmen's discussion of the activities of this component county society (with its membership in excess of 3,000, one of the largest in the United States) is of sufficient interest to be called to the attention of other component county units.

Few county organizations are able to present financial and other reports, so satisfactory. Article follows:

It is the traditional duty of the secretary, from time to time, to report to the membership concerning the activities, assets, obligations and problems of their Association. Actually, of course, though *The Bulletin* and the numerous general, section, and branch meetings, all interested members are already well informed, at least as to those matters in which they particularly are interested. Nevertheless, a résumé may be of value.

#### *Problems of Reconversion:*

The return of many of our members who have been in service presents problems which are not yet clearly defined. We do not know how many men will be quickly released, nor how many will remain in the service, either permanently or for a long time. A number may remain with the Veterans' Administration or with other governmental agencies. Those who do return will sometimes find their old offices occupied by other doctors or by persons engaged in other lines of business. As defense plants close and unemployment grows, the demand for medical service diminishes. During the past two weeks it has become difficult to obtain employment on salary for those doctors who desire it.

The story so familiar to those of us who served in the last war is being repeated. When a man enters military service in wartime he is a great hero. As soon as the war ends the glamor evaporates, the canteens close, heroism becomes a bore and the soldier must struggle for his old place against the unequal competition of entrenched civilians. The tendency of human beings to bear resentment against those to whom they are deeply obligated is partly responsible for this attitude, and it is unfortunately aggravated by the very small percentage of veterans, many of whom never saw action or came to any harm, who become pension chiselers, street sellers of worthless "patriotic" trinkets, and whose attitude is that a period of military service, however brief, entitles one to public support and admiration for life.

The Postwar Planning Committee of the Association, in whose capable hands have been placed the problems of the returning veteran members, are themselves almost all veterans of military service. They know the situation from personal experience and will do everything in their power to assist our military colleagues to reestablish themselves in civilian practice. A fund of \$39,257.50, contributed by members, is at their disposal for the purpose. Dr. Donald Charnock is chairman of the Committee. This Committee also has made plans to provide postgraduate training for those who desire it.

One of the first activities of this Committee was to contact medical schools and all hospitals to insure that all teaching and staff positions held by military members would be open upon their return to civil life. Lack of office space constitutes the most serious and difficult problem today. Information relative to this is up to date and available at the office of the Association, together with other information that might be helpful. Salaried positions once plentiful and other openings have largely disappeared with the end of the war.

#### *The Bulletin:*

*The Bulletin* has grown in thirty-five years from a single small sheet bearing a program announcement, to a semi-monthly magazine averaging forty-eight pages. It is the particular problem of your secretary, who is also the editor, and who is most ably assisted by Mr. Cochems as managing editor, Mr. Bert Fitzgerald, who is in charge of advertising, and Miss Katherine Genter, assistant editor.

*The Bulletin* is said to compare favorably with similar publications in other large cities. It is a very necessary medium in a society so large and scattered over so great an area. Paper restrictions during the war have prevented expansion of *The Bulletin*. It should, however, become much more of a vehicle for scientific articles than has been the case. Members are urged to contribute. Papers, for the present at least, should be on topics of general rather than highly specialized interest. The topics need not be medical, but must be of interest to physicians. Brevity is important. Long articles are seldom of interest except to students of a particular topic. Most subjects can be adequately presented in 1,000 to 2,000 words if rehash and unnecessary detail is omitted. Papers presented at meetings, either branch, section or general, should be sent to *The Bulletin* for publication if they are suitable in the opinion of the author and the officers of the group to whom the essay is presented. Much valuable material, now heard by only a small group could be made available in this way to the entire Association. *The Bulletin* pays its own costs of printing and distribution and also a substantial profit to the Association.

#### *Financial:*

The Association is in excellent financial condition. It has no debts, owns valuable real estate, some income producing real estate in addition to that used as headquarters and library. The Medical Milk Commission is

self-supporting. Securities, largely government bonds, are held. Current and past financial statements are on file at the office of the Association and members are invited to inspect them. In recent years dues have been \$37.50 annually. Of this sum \$20.00 has been forwarded to the California Medical Association for its support.

Each branch of the Association is refunded \$5.00 from the dues paid by members of the branch. This is done for the reason that members in outlying cities do not have the same convenient use of the library and headquarters facilities as those who live in Los Angeles. It will thus be seen that the portion of the total dues paid which goes to the local Association is small. Actually, they would have to be much larger if it were not for wise real estate investments in the past and the income provided by *The Bulletin*. Our excellent library and innumerable services to members simply could not be maintained at \$17.50 per year per member.

#### *Association Dues for 1946:*

Although ample publicity has been given to it, some members may not know that the House of Delegates of the California Medical Association voted at its meeting in May to set State dues at \$100.00 for next year. This was done in the belief that in these unsettled times, with problems of reconversion, postgraduate education, rehabilitation of members and legislation pending, the California Medical Association should be in a strong financial position. In all probability, dues will revert to normal for 1947. If our county dues are fixed by the Board of Trustees at the same level as last year, which seems probable, each member will receive a bill for dues next year of \$117.50. It might be well to put \$25.00 a month into the sugar bowl between now and the evil day, which is January 1st, just to soften the blow. The writer has not been greatly impressed with the wisdom of some of the expenditures of our State Association. There may have been a tendency to run after plausible messiahs who promised great accomplishments—for a large consideration. Regardless of past expenditures, the large fund is necessary, and if wisely used and not squandered, it will be well worth while. A heavy responsibility will rest upon the State officers, council and House of Delegates.

#### *The Library:*

Our library has gained international recognition. Its accretions continue and space for books and magazines is again becoming something of a problem. It will be necessary to find additional storage space before many years. Miss Hazel Granger, librarian, has a highly efficient staff, all of whom have been overworked. In addition to the normal demand for research and other service, the military establishments have made heavy demands upon the library staff. Because of wartime restrictions on the employment of labor, it has not been possible to obtain additional librarians.

#### *Medical Milk Commission:*

The supervision of certified dairies and the inspection of milk is one of the oldest activities of the Association. The members of the Milk Commission—Drs. John P. Nuttall, chairman; Oscar Reiss, secretary-treasurer; Philip Stephens, Howard F. West and E. Earl Moody—are to be congratulated on the excellent record they have made.

Certified milk in Los Angeles County today is recognized nationally as the purest and highest quality raw milk ever produced in the history of milk production. The laboratories of the Milk Commission are maintained at 821 West 37th Street, Los Angeles and are the charge of Charles W. Bonyng, M.D., bacteriologist, who has serving with him Dr. J. J. Hird, veterinarian; Gerhard D. Ruth, M.D., medical examiner, and three technicians.

The certified milk production of three dairies, Arden, Adohr, and Jessup Farms, with herds totaling approximately 3,000, comes under the supervision of the Milk Commission. The testing of cattle and milk and also the examination of employees of certified sections of the dairies is a continuous procedure which has been maintained during the war years at a high standard in spite of the difficulty in retaining sufficient personnel.

#### *The Secretary's Office:*

The Association is most fortunate in its employees. In charge is Mr. Stanley Cochems, diplomat *par excellence*, public relations expert, managing editor of *The Bulletin*, and radio commentator. If any other medical organization possesses an executive secretary of equal versatility, soundness of judgment and personal popularity he has not come to your secretary's attention.

Assisting Mr. Cochems are Mr. Bert Fitzgerald, Mabel Robinson, Margaret Eggerts, Mary Thomas, Katherine Genter, Louise Kalinich and Louise Kirnig. The office of the Association is the nerve center of the varied and multitudinous activities of an Association larger and more active than many state medical associations.

Through this office are handled all the financial and routine activities of the various departments of the Association, the library, the Milk Commission, etc. It is the editorial, advertising and circulation headquarters for *The Bulletin*. It is the meeting place for committees charged with protecting and promoting the interests of the profession. From it radiate public relations activities most vital to the maintenance of public respect and understanding. Possibly one of the most important activities of the office and its staff is to keep in constant touch with the status of medicine in this community and the wishes and attitudes of the more than three thousand members of the Association, and to be a source of authentic information for members and the public alike; to be recognized by government agencies, by business organizations and by individuals as the authoritative headquarters for ethical medicine in Los Angeles County. This recognition during the past decade has been achieved.

#### *Medical Malpractice:*

Medical malpractice constitutes one of the most serious problems that the profession has ever been compelled to face. There will be no real solution until every physician becomes cognizant of his responsibility in relation to the problem. That desirable and necessary state has not yet been reached, but great progress has been made.

About one thousand of our members are now participating in the malpractice insurance and claims prevention program of the Association. Among the basic propositions of this program are that premiums will be paid as may be necessary to assure a reasonable profit to the carrier; that a continuous claims prevention campaign be maintained; that claims handling be conducted by specially trained personnel, and that defense of actions be in the hands of the most capable attorneys available.

Much credit must be given to the Committee on Medical Defense—Louis J. Regan, M.D., chairman; J. Severy Hibben, M.D., and Donald Tollefson, M.D. Members of this committee have worked indefatigably and without stint of time to develop a real protection to members of the Association.

#### *Diamond Anniversary:*

On January 31st, next, we will observe the 75th anniversary of the founding of the Los Angeles County Medical Association by a group of seven physicians who met in the offices of Doctors Griffin and Widney in Wohlschlag's drug store near the plaza. Through the years it has grown, slowly and haltingly at times, until it has now become greater than all but a few state medical associa-

tions. A comprehensive history of the Association will be published to mark the occasion. An intensive search for historical material has been in progress for several months and much has been learned.

The real growth of the society began when Doctor George H. Kress assumed the duties of secretary on January 1, 1910. Stagnation had prevailed with no more than four members a year being added in the preceding years. Doctor Kress' enthusiasm and energy was such that fifty-five new members were acquired in his first year, and one hundred-four in the second. When he laid down the reins eight years later, having meanwhile been honored with the presidency of the California Medical Association, the membership totaled 900, an increase of 498. A highly useful telephone exchange, now outgrown, had been put in operation, a library established, and the American Medical Association entertained in annual convention, a building fund of nearly \$10,000 accumulated and interest and fellowship brought to a high level. Organized medicine in California owes much to Dr. Kress. For thirty-five years he has served his profession loyally and unceasingly without thought of reward and at great personal financial sacrifice. No living member of the California Medical Association can even approach his long record of service in planning, organization, editing, historical research and in the fields of medical education, postgraduate training and elevation of standards. It is to be hoped that Dr. Kress, with the youthful vitality and optimistic viewpoint, in which he excels most men twenty-five years younger, may be spared to us for many years and that he may complete the history of medicine in California which he has in preparation.

Succeeding secretaries have also contributed much to the growth and solvency of our county association, and it is planned to pay tribute to them and to other loyal and distinguished officers and members at a banquet for all members, on the evening of Thursday, January 31, 1946.—E.T.R.

## CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

### **Release from Army of Doctors Made Easier**

An Army announcement on September 14 stated that no officer or enlisted man with 40 or more discharge points will be sent overseas.

The previous overseas point limit for marines was 70.

The Army estimated 13,000 doctors, 25,000 nurses and 3,500 dentists will be civilians again by January 1.

The Army system will be liberalized still further within a few months so that by July 1, 1946, when the Army strength drops to 2,500,000, at least 30,000 doctors, 10,000 dentists and more than 40,000 nurses will be out of uniform.

In addition, large numbers of veterinarians, Sanitary Corps officers, dietitians, physical therapists and medical administrative officers will be released.

### **How Release Works**

Under the new system, doctors and dentists—with the exception of about 200 specialists—will be released if:

They have 80 discharge points, based on credit for service, combat and parenthood or are 48 years of age or older or entered service prior to December 7, 1941.

The specialists will be released if they have 80 points or are 48 years of age, or if they went on active duty before January 1, 1941.

The discharge score for nurses was lowered from 65 to 35 and the discharge age from 40 to 35. In addition, they also may get out if they are married or have dependents under 14 years of age.

#### **Navy Release Program Told in Senate Quiz**

Vice Admiral Louis E. Denfield, chief of personnel, on September 17, before the Senate Military Committee, testified the Navy plans to release 3,000,000 men by September 1, 1946, bringing the total down to 57,800 officers and 500,000 men.

#### **Surgeon General Kirk Urges Prompt Release of Eligible Personnel**

Major General Norman T. Kirk, in a bulletin dated September 30, 1945, the Surgeon General of the Army, expressed the desire that all commanding officers give the fullest possible cooperation towards effecting the early release of Medical Department personnel who are eligible for separation from the service under the announced policy.

At the same time he urged that all Medical Department personnel occupying key positions and who are eligible for separation under the present criteria volunteer to continue on active duty to assist in maintaining the present high standards of medical care if no replacement is immediately available. It is contemplated that a period of six months' duty will be sufficient time to allow for the arrival of a replacement or for training an officer to take over duties of key positions and thus allow all officers eligible for release to be returned to civilian life.

General Kirk requested that commanding officers make every effort to obtain replacements for Medical Department personnel eligible for release in order that those officers might be returned to civil life at the earliest possible moment.

Under the announced Medical Department demobilization policy, Medical and Dental Corps officers are eligible for release providing they meet any one of the following criteria:

- a. Adjusted service score of 80 or above.
- b. Forty-eight years of age to the nearest birthday or above.
- c. Entry on active duty prior to Pearl Harbor excepting critical specialists qualified in eye, ear, nose and throat, plastic surgery, orthopedic surgery, neuropsychiatry or laboratory clinicians. Officers qualified in these specialties are eligible for release if they entered on active duty prior to 1 January 1941 or if they meet the criteria on points or age.

This revised policy on separation is expected to return 13,000 physicians, 3,500 dentists, 25,000 nurses and a large number of other Medical Department officers to civilian life by the first of the year.

It will be necessary to retain a large number of low score men in the service for replacement for overseas men having high ASR scores. Other low score men must of necessity be retained in the service to carry on the necessary activities of the Medical Department in this country and in theaters where American troops are operating.

It is intended that no one eligible for release will be held in the Army because there are men with higher scores overseas who have not been returned home. Eligible men will be discharged as rapidly as they can be processed for separation.

No enlisted personnel with a sufficient number of critical points will be kept because of "military necessity" except those very few men classified in one of three essential technical skills. These are: Orthopedic me-

chanics, electroencephalographers who operate electrocardiac equipment and radio transmitter attendants. The latter is not in the Medical Department.

#### **A.M.A. Washington Letter of September 24:**

##### **Army Mismanagement of Medical Manpower Charged**

Col. W. Paul Holbrook, testifying before the Senate Military Affairs Committee as an investigator to survey army medical needs, said that too few doctors had been used by the Army at the front and too many behind it. He claimed that the armed forces had taken 60,000 doctors for the 12,000,000 men in uniform and had left only 90,000 at home to care for 120,000,000 civilians. He declared that there were too many doctors for service personnel and that determining the number of physicians required on the numerical strength of units was a "fundamental fallacy" of the army system. Colonel Holbrook said that 50 doctors assigned to a 15,000 man infantry division were "far too many for preventive medicine to healthy young men, yet far too few on the field of battle." Despite this, he pointed out, this number of doctors was assigned to a division whether or not it was at the front or in an inactive theater.

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##### **More Hospitals and Doctors Required by Veterans Administration**

Veterans Administration officials are now checking on additional hospital and medical personnel needs of the agency, expected to be heavy as increasing numbers of servicemen are discharged. General Omar N. Bradley, new veterans administrator, with Major Gen. Paul R. Hawley, acting Veterans Administration Surgeon General, and Brig. Gen. H. B. Lewis, acting director of organization, and other aides, conferred at Atlanta, Ga., with agency officials from eight Southeastern states.

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##### **Navy to Release 1,678 Reserve Medical Officers**

Vice Admiral Ross T. McIntire, Surgeon General of the Navy, informed the Senate Military Affairs Committee that the Navy would release 1,678 of its 12,000 reserve medical officers under the point system by January 1. He explained that they will be released at the rate of 880 a month, starting January 1, and that 8,000 will be out by the time the Navy reaches its postwar goal of 550,000 officers and men next September 1. An effort will be made to keep medical discharges up to the pace of demobilization of fighting personnel.

##### **Professional Training Planned for Army Doctors**

In order to provide qualified doctors for the peacetime, Army plans have been formulated to interest Medical Corps officers who are serving for the duration of the war to apply for commission in the Regular Army, Major General Norman T. Kirk, Surgeon General of the Army, announced recently.

Among the more important attractions which will be offered Medical Corps officers who remain in the Army are the following:

1. The Regular Army Medical Corps officer will be assured a professional career offering broader possibilities in a larger field than the practice of the average civilian doctor affords.
2. The training and the assignments of Army doctors will be arranged to aid the Army doctors in obtaining board certification for specialties from the recognized civilian specialty boards.
3. Graduate training will be continued with the estab-

lishment of Army fellowships, residencies and special courses.

In addition to the above attractions, which carry decided weight with any professional man, the Army affords security in its pension system, hospitalization care and other considerations not usually available in civilian practice, General Kirk said.

Civilian practice on the whole involves considerable uncertainty, and the locality in which a man has established himself and other factors seriously limit the scope of the practice a doctor can engage in, General Kirk said.

This program which is being inaugurated is designed to obtain and utilize to the best advantages the professional skill now available in the Army, according to Colonel Floyd L. Wergeland, Director of the Training Division of the Surgeon General's Office, and Chairman of the committee handling the professional training of Army doctors.

The plans under this policy call for the establishment of graduate training programs at Army Installations where the residencies will meet the requirements of specialty boards and arrangements will be made for accrediting by the appropriate specialty boards, Colonel Wergeland said. Another phase of the program includes the establishment of Army internships at selected Army general hospitals.

Plans outline a procedure for giving professional rehabilitation and specialized training to Regular Army Medical Corps officers who have been in administrative work during the war. These doctors who have not been able to engage in practice because of administrative responsibilities will serve as understudies with doctors who have been active in professional practice. This assignment will lead to continued professional service and eventually specialty board certification.

Medical Corps officers in the Regular Army will be kept in professional capacities without material interruption under this plan.

The advantages of a professional career in the Army will also be brought to the attention of medical students to interest them in an Army commission. Only those who stand scholastically in the upper third of their classes will be prevailed upon to consider the Army for a career.

Reserve or AUS officers now on active duty who desire consideration for commission in the Regular Army may forward through channels Statement of Interest to War Department Adjutant General's Office in accordance with the provisions of War Department Circular 243.

Civilian physicians and former Organized Reserve Corps and AUS officers now on inactive duty status may submit Statement of Interest direct to the Adjutant General's Office.

Future announcements as to securing commission in Regular Army Medical Department will be publicized in current professional and military publications.

#### Hospitals Named for Refresher Training Courses

On September 10, 1945, the Surgeon General notified the Commanding Officers of the following hospitals that their medical services had been approved for the professional refresher training of Medical Corps officers to extend over a twelve week period:

Cushing General Hospital, Framingham, Massachusetts  
Mason General Hospital, Brentwood, Long Island, New York  
Valley Forge General Hospital, Phoenixville, Pennsylvania  
Kennedy General Hospital, Memphis, Tennessee  
Newton D. Baker General Hospital, Martinsburg, West Virginia

Percy Jones General Hospital, Fort Custer, Michigan  
Winter General Hospital, Topeka, Kansas  
McCloskey General Hospital, Temple, Texas  
DeWitt General Hospital, Auburn, California

Medical Corps officers desiring refresher training in neuropsychiatry will be permitted to serve the entire twelve weeks on the neuropsychiatric services and to rotate through the various wards of the neuropsychiatric services in order to gain experience in all phases of neuropsychiatry.

The refresher course will follow Guide for Professional Refresher Training for Medical Corps Officers approved by SPTRU 353 (Med.) (Nov. 13, 1944), dated November 17, 1944.

#### General Rankin in Talk on Work of Army Surgeons

A major factor in the Army's record of saving the lives of almost 97 out of every 100 wounded men who reached a hospital was the quality of surgical care given these soldiers, Brigadier General Fred W. Rankin, Chief Consultant in Surgery of the Army Medical Department, told the graduating class of ASTP and V-12 students at the University of Michigan School of Medicine on September 15 at Ann Arbor, Michigan.

The lowered mortality rate in this war also was achieved because the highly qualified surgeons did their work without loss of time and also because hospital facilities staffed by specialists were placed near the front.

General Rankin said the average wounded man received his initial surgery at an evacuation hospital within ten hours of the time of his injury.

"In carefully selected cases," General Rankin added, "in which surgery was done at field hospitals the average time lapse was considerably less."

The efficient operation of the Army chain of evacuation made this possible. It starts at the time a man is wounded, and it is usually only a matter of a few minutes before the Medical Corpsman gives emergency treatment.

General Rankin explained that the Army's accomplishments were possible partly because of the method of assigning qualified specialists and also to the dissemination of information through the Consultants Division as to the best methods to be used under certain circumstances.

"The general principles of wound management were two-fold; initial debridement and delayed wound closure," the General continued. "The use of this method in the Mediterranean Theater of Operations resulted in primary healing in 95 per cent of the cases in which it was used and was attended with no loss of life or limb and with no serious complications."

Improved techniques reversed the ratio of deaths and survivals in abdominal injuries as compared with that of the last war. About 60 per cent of the casualties in the last war were fatal, while in this war 60 per cent of such casualties survived.

The so-called early nerve suture resulted in regeneration in 85 per cent of the cases in this war, according to the General. Another notable accomplishment in this war has been the reduction in the mortality rate in the dangerous cases, or the head, chest and abdomen wounds, which is only half as high as during the last war.

Reconstructive and rehabilitative surgery designed to correct the disfiguring consequences of battle wounds is achieving results "that can fairly be termed miraculous," General Rankin said.

#### Neuropsychiatric Discharges in Army Now Total 315,000

The nation's total of soldiers who have been discharged from the Army for neuropsychiatric reasons has now reached 315,000, Brigadier General Williams C. Men-

ninger, Director of the Neuropsychiatry Consultants Division of the Army Medical Department, said in a recent (October 8) talk before the New York Academy of Medicine.

Describing this problem as a "postwar challenge to medicine," General Menninger expressed the hope that "physicians will prepare themselves to accept and treat what the Army medical officers discovered were among their biggest problems—the emotional factors in the production of illness."

"With this understanding on the part of the physician," General Menninger said, "treatment must be directed towards integrating the individual into his pre-war identifications and satisfactions."

On the basis of the Army's experience with neuropsychiatric cases, which are referred to as combat exhaustion or combat fatigue, only about 3 to 5 per cent of the soldiers suffered reactions due entirely to fatigue. The condition of the great majority was primarily a personality disturbance and treated as such, he explained.

Upon induction into the Army a soldier faces an entirely different life which in certain cases produces sufficient stress in the individual to bring him to the psychiatric breaking point.

"Frustration," he pointed out, "was a daily part of the soldier's life, sometimes in the form of waiting days, weeks, months, sometimes in the deprivation of essential supplies.

"Confusion was routine in his life and the noise and whistles and flares of battle are beyond the imagination of anyone who has not heard and seen them."

General Menninger said that essentially the response is the same when an individual fails to adjust himself to his situation in civilian life as it is when he finds he cannot meet the demands of Army life.

#### Age of American Military Leaders

When Nazi Germany unleashed its fateful blitzkrieg in Europe six years ago, the Regular Army of the United States comprised less than 200,000 men under the leadership of about 100 Generals.

By the time Germany capitulated early in May of this year, our Army, including the Air Forces, numbered well over 8,000,000, and when the surrender of Japan brought the war to a close in mid-August, the total in this service was not very appreciably smaller. The top leadership during the war period had increased to more than 1,500 Generals.

On July 1, 1945, there were 1,539 Generals in our Army, and their average age was 51.4 years. Almost 35 per cent of the Generals were under 50 years of age, a slightly higher proportion were concentrated in the age group 50 to 54, while an additional 20 per cent were in the age period 55 to 59; 8 per cent were 60 to 64, and less than 2 per cent were 65 years or over.

At the lower end of the list of Generals are the Brigadier Generals who constitute 70 per cent of the total number; their average age on July 1st was 50.3 years, or ten years below that for the Generals of the Army and five years below the average for Lieutenant Generals.

#### Army Medical Conference at Auburn

More than 160 medical men from all branches of the armed forces in the Ninth Service Command met on September 14-15, at DeWitt General Hospital in Auburn, California, for an intensive two-day program of study.

In addition to medical discussions and illustrated movies, the doctors made ward rounds to see at first hand illustrations of topics in the following hospital sections: Vascular, neurosurgical, orthopedic, dermatology and paraplegic.

#### Mollycoddling of Wounded Found Ruinous for Morale

The staff of Birmingham General Hospital at Van Nuys in Los Angeles County, on August 27, found their policy of "no sympathy" for wounded veterans upheld by the Army's surgeon general, Maj. Gen. Norman T. Kirk.

"Mollycoddling of wounded war veterans will ruin their morale and turn them into sympathy-seeking bums," General Kirk said. "I saw it after the first world war and it almost made me cry."

He added "There is a high standard of morale among the wounded veterans of this war which, if untampered with by mistaken people, will carry them through an independent postwar life.

"We will find them well able to look after themselves as long as they are not made to feel that they are a burden," he said.

Birmingham Hospital has been training and educating war casualties in every phase of useful civilian life—from gainful employment and new professions to their mental attitude toward civilians.

The Surgeon General praised the work of the medical services which, he said, had brought the overall death rate down to approximately 3 per cent. He attributed the low death rate from wounds to a "combination of factors including quicker attention to wounded men on the battlefield, faster evacuation, outstanding surgery, equipment and hospitalization."

With 300,000 wounded men in hospitals in this country and all casualties from the Pacific expected home within 90 days for treatment an average of five and a half months, General Kirk reemphasized that doctors are still sorely needed for the medical corps.

He said the medical men will not be released as rapidly as the combat veterans.

#### Veteran Suffers

On the question of government-sponsored medical care, too much emphasis has been placed on the doctors versus the government. In between are the people, and they are the ones who stand to gain or lose the most. As more than one doctor has pointed out, if State medicine is thrust upon the medical profession and the doctors don't like it, those who wish can escape by merely switching to some other line of business. But for the people, there is no escape. If State medicine is adopted and results in lowered medical standards there will be nothing the people can do about it—socialism is a one-way road. The people will be socialized, not the doctors.

The medical profession opposes State medicine because it has studied the lessons of history and knows that too much government in medicine will not bring adequate medical care to all the people. A tragic example of State medicine can be seen in the veterans' hospitals. Many veterans are getting worse than poor medical care all because their treatment is swamped in red tape—politics takes precedent over the requirements of good medicine. And who has suffered the consequences, the veteran or the doctor? Ask the veteran!—San Francisco *Underwriter's Report*, August 9.

#### Civilian Psychiatrists Report on Army Neuropsychiatric Work

The commission of outstanding civilian psychiatrists appointed by the Office of Scientific Research and Development at the suggestion of the Surgeon General for a study of the Army's neuropsychiatric work overseas reported that as a result of prompt and skilled handling of combat exhaustion cases approximately 90 per cent of these men are returned to duty, Colonel William C.

Menninger, Director of Neuropsychiatry Consultants Division of the Office of the Surgeon General, has announced.

Members of the commission at a recent meeting in the Office of the Surgeon General were generous in their praise of the exceptionally fine psychiatric work that is being accomplished in the European Theater of Operations where they visited for eleven weeks, Colonel Menninger said.

Combat exhaustion cases, known as shell shock in the last war and sometimes referred to as combat fatigue or operational fatigue, are being treated more successfully in this war because of the high quality of personnel in the field, better methods and techniques, and of the greatest importance is the fact that our psychiatrists are getting to the men sooner than ever before, according to the findings of the commission. The Army psychiatrists are doing some of their most effective work right up near the front at the clearing stations.

There is some variation in the treatment given. Sedation, narco-synthesis, hypnosis, and the new technique of group psychotherapy were some of the methods of handling these battle-weary soldiers. The results of group psychotherapy were, in general, particularly encouraging.

Dr. Menninger brought out the fact that an alert and understanding sergeant or lieutenant can anticipate a case of combat exhaustion. Symptoms are increasing irritability, lack of interest in letters from friends or family, lack of interest in comrades, and the throwing away of equipment and food. A man who has reached this stage, but who has not yet come to the breaking point can usually be brought back to normal with the help of a proper rotation plan to give the necessary rest and relief from the stress of battle.

There is a direct ratio between the number of exhaustion cases and the intensity of combat, Dr. Whitehorn pointed out. The number of combat exhaustion cases is almost always just about one-fifth the number of wounded cases.

Every man has his breaking point, according to psychiatrists. It is just a matter of how much stress and strain is put upon a man and for how long a period. The fact that combat exhaustion cases bear a direct ratio to the number of wounded shows that as the battle becomes more intense the pressure is just that much heavier, causing more men to reach the breaking point.

A factor that leads to combat exhaustion is the martyr situation, Dr. Whitehorn said. When men are unavoidably marooned from the main body of troops so that the situation seems hopeless, or when they are on a mission which they do not understand and which seems futile or when they are isolated and lose their leader, the average man is more likely to become subject to combat exhaustion under such circumstances.

The commission's report will stress the fact that combat exhaustion does not mean that a man is "yellow," or a coward. A big percentage of the combat exhaustion cases represent men who have had long months of service at the front as effective and brave fighting men. They simply come to the point where the human system can take no more. It is then that the psychiatrists start to care for the ailing soldier.

This commission will submit a formal report of its findings to the Office of Scientific Research and Development, Dr. Bartemeier announced.

#### **Total Streptomycin Production Only Fourteen Ounces a Month**

The War Department recently said that streptomycin, the new wonder sister drug to penicillin, was being used in 30 Army general hospitals over the country, but that

it was so difficult to obtain that the total output of the four companies now making it has been only 14 ounces a month.

Major General Norman T. Kirk, Surgeon General of the Army, said the Army was receiving many requests for the drug for use in treatment of urinary and other infections caused by gram-negative bacteria which do not respond to penicillin, but that these cannot be met since the Army neither controls the supply nor can get enough for its own needs in treatment of battle-wounded soldiers.

General Kirk said that the four companies, Merck, Upjohn, Abbott and Squibb were the principal manufacturers of the new product, but that other concerns were working at experimental production at pilot plants and that any civilian request for streptomycin naturally would go to these companies.

"The Army and Navy are purchasing only a part of available production," General Kirk said. "In August, 28 ounces—or 800,000,000 units—were purchased. Joint Army-Navy expectations for September are 162 ounces, but it is anticipated that production will be not more than 70 ounces. It is hoped that Army-Navy procurement can be doubled in October—for military needs alone now are about 2,000 ounces a month."

A gram, or 1,000,000 units is the standard daily dose administered in three injections over a twenty-four hour period.

Production is limited severely because the drug is obtained from a natural fungus found in the soil and must be grown under carefully controlled laboratory conditions which cannot be hurried.

The phenomenal production of penicillin which brought it from a laboratory curiosity to a commonly-used drug and the price from astronomical figures to about a dollar a dose was due in part to pressure of wartime needs, the General pointed out.

"But," he added, "with the war ended and priorities a thing of the past, streptomycin does not have these advantages, thus working to some extent to hamper production, although industry is doing what it can do supply the demand."

General Kirk explained that the Army's principal needs are for treatment of soldiers with severed spinal cords who develop urinary tract infections because of a loss of bladder function, and to some extent in treating some cases of meningitis and other infections which do not respond readily to penicillin therapy.

**Military Clippings.**—Some news items of a military nature from the daily press follow:

#### **Two-Front War Cost U. S. 252,885 Lives Lost and \$287,181,000,000**

Washington, Sept. 1. (AP).—European and Pacific combat casualties—both Army and Navy—included 252,885 killed, 651,218 wounded, 43,969 missing and 122,747 prisoners.

There were 17,300 surgical amputations; 7,300 men were deafened to some degree; 1,190 were blinded in one or both eyes.

The war cost us a total of \$287,181,000,000, compared with \$280,000,000,000 spent by Germany, \$49,154,000,000 by Japan and \$135,856,000,000 by Russia, our nearest allied competitor in the spending line.

#### **\$119,000,000,000 Taxes**

Americans coughed up \$119,346,228,000 in taxes during wartime. War-developed Treasury indebtedness will hit \$208,226,445,700 with War Bond subscriptions and all other securities.

We lend-leased \$39,000,000,000 in supplies of all kinds to our allies.

Agriculture produced \$20,000,000,000 in food for the armed forces, lend-lease and foreign relief. Even with agricultural manpower reduced by military calls, production reached a peak increase of 35 per cent over the pre-war level.

The war effort meant a \$20,300,000,000 expansion in the country's manufacturing facilities—more than 13,000 facility additions—with the major share of the costs coming from public financing.

#### Loss by Strikes

A peak of 10,300,000 workers was reached for the munitions industry alone—approximately one munition-maker for every manjack in our more than 11,000,000-strong Army and Navy.

With 14,070 labor strikes between Pearl Harbor and the end of July, 1945, the cost in mandays was 34,787,000, one-tenth of one per cent of all available working time.

#### Last Year's Production

As we entered the final year of war the U. S. was producing 45 per cent of the world's munitions. We had raised our synthetic rubber production from 8,000 tons in 1941 to 753,000 tons in 1944, trebled our aluminum output from 1942 to 1944, increased production of aluminum 50-fold in five years.

Our Navy was built up to a two-ocean armada of more than 100,000 vessels of all sizes, including 1,500 fighting ships—a fleet larger than the combined navies of the rest of the world. Just before the war ended the Navy reported we had lost a total of 431 "naval vessels."

American shipyards produced about 60,000,000 dead-weight tons of merchant ships, and we lost about 7,000,000 tons.

As for airplanes: From December, 1942, to VJ-Day, 223,444 aircraft of all types were produced—from tiny trainer planes to B-29's—and the figure includes 184,433 tactical craft.

#### Shoes to Locomotives

Also the Army alone procured:

Tanks, armored cars and self-propelled vehicles—119,400.

Artillery pieces of all types—1,116,000.

Small arms—18,900,000.

Tractors, bulldozers and other construction equipment—180,000.

Trucks—2,400,000 (including 660,000 jeeps.)

Radio sets of all types—1,700,000.

Telephones—2,660,000.

Tents—29,000,000 (which includes "shelter-halves" or two-piece pup tents.)

Shoes—117,000,000 pairs.

Locomotives—7,000.

We reached a peak of supplying 625,000 tons of paper-board a quarter to the armed forces for the packaging of thousands of items from foods to munitions.

#### Regulation by O.P.A.

Amid blackouts and brownouts, car-sharing and bundle-hauling, citizens saw O.P.A. price regulations applied to some 8,000,000 articles and services. They learned to get along under the rationing of the most essential items for living except clothing—and hustled down to the blood-donor center to give a total of 13,300,000 pints.

The nation's railroads handled some 32,000,000 Army troops in organized movements and 287,000,000 tons of Army freight.—Los Angeles Times, September 2.

#### Japanese Military Vital Statistics

Government reports to the Japanese Diet on September 5, disclosed that Japan claims to have suffered only 656,278 casualties in dead, wounded and missing during the war, according to incomplete figures.

Included in this figure are 40,000 army personnel who died from illness out of 4,470,000 listed as "sick," which raised the total casualties to 5,086,278. The army was reported to have lost 310,000 killed, 146,000 wounded and 4,470,000 sick, of which 40,000 died. The navy reported 157,365 killed, 1,430 dead from sickness and 1,483 missing.

Other reports said that the single atomic bombs dropped on Hiroshima and Nagasaki had made those cities the second and third hardest hit in the Japanese home islands, with Tokyo, pounded by months of Superfortress fire attacks and carried plane raids, the most heavily damaged.

Tokyo lost 149,556 killed and wounded, Hiroshima lost 108,760, and Nagasaki prefecture lost 130,000. Total air raid casualties in the home islands were 554,350, including 211,309 killed and 313,041 wounded, and the destruction of 2,333,388 homes making 8,045,094 people homeless. Of these 2,578,150 were made homeless in Tokyo.—San Francisco Chronicle, September 7.

#### Says Army Doctors Not Fully Utilized

Washington, Sept. 13—(AP).—A War Department spokesman told Senators today that the Army had not fully utilized the services of its physicians.

The testimony by Colonel W. Paul Holbrook, a doctor

and a member of the War Department general staff, promptly brought from Senator Downey (D., Calif.) the comment that there had been "a vast and unwarranted waste of medical service" during the war.

Colonel Holbrook appeared at the Senate military committee's hearing on demobilization to tell of a special study of Army use of doctors, dentists and nurses which he made for the committee.

He testified that some 17,000 doctors will be returned to civilian status before January 1.

He explained that Army doctors were assigned much like firemen, whereas they should have been used only in emergencies. For example, he said the average division had fifty doctors, or one doctor for 300 men—"far too many for simple medical care."

At the same time, he said, this was "too few" doctors for Army units that faced heavy casualties.

As Senators listened intently, the witness said that the Army and Navy had taken some 62,000 doctors for armed forces, leaving only 90,000 physicians for the civilian population. He said this resulted in slightly more than six doctors for every 1,000 men in military services and left only one civilian doctor for every 1,500 civilians.—San Francisco Call-Bulletin, September 18.

#### Another Revision of Army Scores

Washington, Sept. 23—(UP).—The Army tonight announced new screening scores which will exempt an additional 300,000 officers and men from overseas service. . . .

For Medical Officers, the requirements for exemption are as follows:

Male officers, Medical Corps and Dental Corps, 45 points or 40 years of age; male officers, Veterinary Corps and Medical Administrative Corps, 30 points or 35 years of age; nurses, 12 points or 30 years of age; Medical Department dietitians and physical therapy aides, 18 points or 30 years of age.

As announced previously, members of the Women's Army Corps will not be shipped overseas.

The new regulations do not apply to members of the Regular Army or to men who have volunteered for overseas service. . . .

This is the first time exemption scores have been computed for officers.

It was disclosed meanwhile that the Office of War Mobilization and Reconversion has been trying without success to get the Navy to demobilize its men at a faster rate. A high OWMR official said that recent informal efforts to persuade the Navy have been unavailing, but that OWMR is still trying. . . .

Answering congressional criticism that many men are being kept in needlessly and that some are performing petty, unnecessary duties, he reaffirmed a pledge that the Army will not keep any man in uniform longer than absolutely necessary.

The OWMR spokesman said his agency is dissatisfied with the manner in which the Navy is demobilizing. He said there are "too many men now sitting around in the Navy doing nothing." No specific rate of discharge was requested.

The Navy's schedule calls for the release of 3,000,000 by September 1, 1946, leaving 50,000 officers and 500,000 enlisted men as the nucleus for its peacetime strength. Present plans call for releasing 764,000 enlisted men and 75,000 officers by Christmas. The rate of discharge is to be increased each month so that by the end of this year the Navy will have 2,390,000 enlisted men and 253,800 officers.

An Army spokesman said over the week end that the War Department will review its demands for peacetime military training if and when results confirm its belief that voluntary recruiting will not provide an adequate armed force. The Army will want a force of some 1,000,000 officers and men, he said, and is convinced that voluntary recruiting will not bring that many.—San Francisco Chronicle, September 23.

**Lane's Kink.**—Treatment of chronic intestinal stasis by short-circuiting the intestine was originally described by W. Arbuthnot Lane in an article entitled, "Chronic Constipation: A Consideration of its Surgical Treatment." Lane is also noted for his work on the treatment of fractures by plates and screws. A prominent British surgeon, he wrote a manual on operative surgery, and during the last war he figured importantly in the administration of surgical service.—Warner's Calendar of Medical History.

## COMMITTEE ON MEDICAL ECONOMICS

### A Kansas Opinion of Mr. Kaiser's National Health Plan

*A Medical Editor's analysis of Mr. Henry Kaiser's article as guest editor for Mr. Drew Pearson's "Washington Merry Go Round."*

Recently Henry Kaiser, as guest editorialist for Drew Pearson, gave a glib solution for all medical-care maldistributions: Get ten G-I medics together, pool their \$2,500 apiece, pyramid this with a \$25,000 bank-loan to build a hospital-clinic and presto—we would have "many little Mayo Clinics" throughout our land. Just like that all difficulties are dissolved. Of course, the sustained financial support of these mushroom institutions is to be contingent on widespread prepayment plans.

His intriguing prospectus would be breath-taking in its broadness of concept and simplicity of design if it were not for a few obvious "bugs" in the syllogism. His major premise is that ten G-I medicos can get together and function as a unit, not rarely and uniquely, but that this coalition would occur generally and commonly throughout the land. In the first place no ten medicos—G-I or otherwise—have ever been known to agree so thoroughly and completely as to cast their entire future and fortune into a common lot except with some form of compulsion. There is something basically and inherently in the training or development of a physician which usually makes him a supreme individualist. He will not pull for long in the same harness with nine (or even two or three) other medicos unless under pressure.

Therefore, Mr. Kaiser's major premise (or first guess) is unsound. Who gets whom together—to form ten men, tried and true? In what town do they settle for this cozy, communal life? Who picks whom for the "captain" of this ten-man ball team? Who becomes what specialist? Which doctor drives the biggest car; on what side of the square do they build this "clinic"? Who gets the biggest "cut" of the financial melon? These are simple, every-day problems which have split asunder more so-called "clinics" in the past than Uncle Henry's production-line techniques ever will produce in the future!

His minor premise involves prepaid costs. Supposing it is a rural area these ten men (if they do agree) have finally decided to honor with their "little Mayo Clinic." Where is the "check-off" system so familiar to Mr. Kaiser? Even our local Blue Cross or other such voluntary pre-payment systems must depend—for their very blood and bone—on a large, pay-roll deduction type of contribution to be really successful. Do you find this in a town of two or three thousand persons? Who actually collects the prepayment monies; who supervises the services rendered (no one is foolish enough to think citizens will just throw so much per capita at this budding "clinic" with no strings attached); what central agency polices the contributor that he does not abuse the system?

Easy, ain't it, Uncle Henry? But as "Doctor" Orday (the Crime Doctor) says: "There is just one little detail" you have forgotten! When physicians speak of the Mayo Clinic, they do so proudly and somewhat collectively. They also mean the Lahey Clinic, the Crile Clinic, and a few others of a like, superior quality. As you speak of it, Mr. Kaiser, it would seem that merely throwing together a bunch of bricks and cement—and a bunch of doctor men, would constitute a "clinic." On paper it may, but this is not a physician's idea of a *real clinic*. This takes "that one little detail," not from the production-line or drafting-board, Mr. Kaiser. It takes a man—or a few men—with drive and vision, more than

just a dandy dream or an idle idea. It requires the ability to *lead*, someone with such strength of purpose that he can *command* a group.

Already there are thousands of "clinics" throughout the United States. They are as real as the penny postcard replicas of a masterpiece. So in this pretty picture you have painted, Mr. Kaiser, do not forget "that one little detail," without which these thousands of "little Mayo Clinics" will be as empty, as worthless and as useless as burnt-out light bulbs. Oh, Mr. Kaiser!—Vincent Williams, M.D., Editor, Jackson County Medical Society *Bulletin*, Kansas City, Mo.

## COMMITTEE ON PUBLIC POLICY AND LEGISLATION

### President Truman's Message to Congress

On September 6th, President Truman sent a message to Congress outlining a twenty-one-point legislative program.

The following excerpts relating to public health and medical service activities have received press association comment:

For carrying on scientific research and development, the President asked Congress to set up a single federal research agency to promote and support research in basic sciences, social sciences, medicine, public health and allied fields. This agency would aid in all projects pertaining to defense and security and make available to commerce and industry the fruits of government financed research.

The President said he soon would ask Congress for a national health program to provide "adequate medical care for all Americans and to protect them from financial loss and hardships resulting from illness and accident."

He also promised a communication with respect to "expanding our social security system, and improving our program of education for our citizens."

For veterans, the President urged that Congress should revise the G. I. bill of rights along the lines of recommendations made by the Veterans' Administration. These include liberalizing hospital and medical care, national service life insurance, and educational and vocational training.

Aprpos of the above, and indicating the extent to which Labor groups maintain an interest in plans for socialized medicine through national supervision, it may be of interest for physicians to note what was stated in the *News Letter* of the "Northern California Union Health Committee" of September 15th. Excerpts follow:

### President to Recommend National Health Program:

President Truman in his message to Congress recently emphasized the necessity for expanding the present social security program, including provisions for national health. The President impressed upon Congress the urgency of legislation that will provide more adequate unemployment benefits, but added that a special message setting forth recommendations for a national health program providing "adequate medical care for all Americans" was forthcoming. Although pressures from the A.M.A. and other opponents of compulsory health insurance are already being exerted upon the President, if the voice of organized labor and other friends of national health insur-

ance is sufficiently strong, the President may recommend the comprehensive and forthright program outlined in the Wagner-Murray-Dingell bill.

Attached to the above *News Letter* was a full page display pink slip which read as follows:

#### *Action! For Social Security*

Write or wire President Truman today. Tell him:

1. That you or your organization welcomed his statement on the importance of expanding social security.  
2. That you or your organization will support his forthcoming recommendations for a national health program.

3. That you or your organization favors the forthright and comprehensive program for national health outlined in the Wagner-Murray-Dingell bill.

The A.M.A. and other opponents of compulsory health insurance are already exerting their pressure upon the President. Let us win this fight!

#### **Murray-Wagner-Dingell Bill**

The *Sacramento Bee* of September 11th contained a statement by the Democratic State Central Committee, outlining ten points that had been devised by a legislative subcommittee of which John Anson Ford of Los Angeles is chairman.

Item 9 therein contained the following recommendation:

A memorial to Congress to pass the Murray-Wagner-Dingell bill for public health facilities and the extension of public assistance programs.

## **COMMITTEE ON POSTGRADUATE ACTIVITIES**

### **Wartime Graduate Medical Meetings**

Note.—The C.M.A. Postgraduate Committee presents below the roster of speakers and topics of "Wartime Graduate Medical Meetings." These listings may have suggestive value to program committees of Component County Societies.

#### **CLINICS, DEMONSTRATIONS, LECTURES**

Under the Auspices of the American Medical Association, the American College of Physicians, the American College of Surgeons

Authorized by the Surgeons General,

Norman T. Kirk, Ross T. McIntire, Thomas Parran

#### *Committee 24th Zone*

Lt. Comdr. Geo. C. Griffith (MC), USNR, Chairman

U. S. Naval Hospital, Corona

Capt. Harry P. Schenck (MC), USNR

Wayland A. Morrison, M.D.

James F. Churchill, M.D.

Program of the Wartime Graduate Medical meetings for Zone 24 (Southern California) follow:

*Birmingham General Hospital—3:00 P.M.*

October 10—"Recent Developments in Surgical and Public Health Antisepsis"—Dr. Fred J. Moore, Prof. of Bacteriology, U.S.C.

October 24—"Communicable Diseases"—Major Norman Nixon

"Acute Infectious Mononucleosis"—Capt. Chas. H. Marple

*Camp Haan, ASF Regional Hospital—3:30 P.M.*

October 2—"Neuro-Psychiatry"—Lt. Comdr. Nichols March Field, AAF Regional Station Hospital—3:30 P.M.

October 16—"Tumor Pathology"—Dr. Edward Butt

*Camp Cooke Station Hospital—1:00 P.M.*

October 3—"Recent Developments in Diabetes"—Dr. Howard F. West

October 17—"Traumatic Surgery of the Urinary Tract"—Capt. D. W. Atcheson

*Hoff General Hospital—8:00 P.M.*

Same programs given at 1:00 P.M. at Camp Cooke Station Hospital repeated here at 8:00 P.M.

*Torney General Hospital—3:30 P.M.*

October 2—"Cardiac Pain"—Capt. Arthur A. Twiss

October 16—"Acute Nephritis"—Prof. Lyttle, Prof. of Pediatrics, U.S.C.

*U. S. Naval Hospital, Santa Margarita Ranch—1:00 P.M.*

October 11—"Penicillin in the Treatment of Syphilis and Gonorrhea"—Lt. Comdr. W. W. Duemling

October 25—"Neuro-surgery"—Capt. Everett Dickinson.

*U. S. Naval Hospital, Long Beach—3:00 P.M.*

October 17—"The Streptococcal Problem"—Lt. Comdr. Geo. R. Underwood

*U. S. Naval Hospital, Corona—1:00 P.M.*

October 11—"Burns"—Capt. H. T. D. Kirkbaum

October 25—"False Biological Reactions"—Major Mark Beam

"Allergies"—Major Iredell Hinnant

*U. S. Naval Air Training Station, San Diego—3:00 P.M.*

October 5—"Acute Infectious Hepatitis"—Col. Irving Wright

October 19—"Psychosomatic Medicine"—Major Milton Miller

"Headache"—Capt. Oscar Sugar

*Santa Ana Army Air Base—3:30 P.M.*

*A.A.F. Regional and Convalescent Hospital*

October 2—"The Streptococcal Problem"—Lt. Comdr. Geo. R. Underwood

October 18—"Endocrinology"—Dr. Hans Lissner

*U. S. Naval Hospital, San Diego—1:00 P.M.*

October 4—"Peripheral Vascular Problems"—Col. Irving Wright

*U. S. Regional Hospital, Pasadena—7:00 P.M.*

October 8—"Thoracic Surgery"—Comdr. W. L. Rogers

### **California Heart Association**

The Sixteenth Annual Postgraduate Symposium on Heart Disease will be held in San Francisco on October 17, 18, 19, and 20, 1945.

Visiting guest speakers include:

*Samuel A. Levine, M.D.*, of Boston, is one of the country's foremost cardiologists, and one of our most beloved and respected teachers. He is the author of "Clinical Heart Disease," a popular and widely used textbook.

*Colonel Irving S. Wright, MC*, Clinical Professor of Medicine, Columbia University College of Physicians and Surgeons, is now Consultant in Medicine, Headquarters, Ninth Service Command, Fort Douglas, Utah. He is a national authority on peripheral vascular disease.

*Louis E. Martin, M.D.*, of Los Angeles, Assistant Clinical Professor of Medicine, University of Southern California School of Medicine is President of the California Heart Association. As Chief of the Cardiac Clinic of the Children's Hospital in Los Angeles he has had wide experience with rheumatic fever.

*James J. Waring, M.D.*, of Denver, Colorado, is Professor of Medicine at the University of Colorado School of Medicine. He is a member of the American Board of Internal Medicine, and a former President of the Board of Directors of the National Tuberculosis Association. Program follows:

WEDNESDAY AFTERNOON—OCTOBER 17, 1945

1:30 P.M.-5:00 P.M.

Univeristy of California Hospital—Toland Hall  
Third and Parnassus Avenues  
*Sessions on Rheumatic Fever*

Sponsored by the American Academy of Pediatrics,  
Northern California  
Crawford Bost, M.D., Chairman for Northern California,  
American Academy of Pediatrics, Presiding

1:30 P.M.  
The Importance of Early Diagnosis in Rheumatic Fever  
Louis E. Martin, M.D., President California Heart  
Association

2:15 P.M.  
Rheumatic Fever: A Military Problem—Lt. Comdr.  
Harold Rosenblum, MC, U.S.N.R.

2:50 P.M.  
Recess  
3:00 P.M.

Clinical Demonstrations of Various Manifestations of  
Rheumatic Fever—Peter Cohen, M.D., Presiding  
Participants

Helen M. Johnson, M.D., Medical Director, Cardiac Program,  
Crippled Children's Services, California State  
Department of Health

Mary B. Olney, M.D., Assistant Clinical Professor of  
Pediatrics, University of California Medical School  
and Director of the Children's Cardiac Clinic, University  
of California Hospital

Alice Potter, M.D., Assistant Clinical Professor of  
Pediatrics, University of California Medical School,  
and Acting Supervisor, Cardiac Diagnostic Center of  
the San Francisco Department of Public Health

4:15 P.M.  
General Discussion—Questions and Answers

THURSDAY MORNING—OCTOBER 18, 1945

9:30 A.M.—12:00 Noon

Stanford University Medical School

Stanford Hospital, Lane Hall

Sacramento Street, Near Webster

Arthur Selzer, M.D., Presiding

9:30 A.M.

The Importance of Diaphragmatic Hernia in the Differential  
Diagnosis of Coronary Artery Disease—  
Walter Beckh, M.D.

10:00 A.M.

Recent Trends in Electrocardiography—  
Arthur Selzer, M.D.

10:30 A.M.

Actions of Digitalis—David A. Ryland, M.D.

11:00 A.M.

Recess

11:10 A.M.

Some Notes Concerning Cardiac Murmurs—  
Samuel A. Levine, M.D.

12:10—1:30 P.M.

Box luncheons will be available in the auditorium  
of the Nurses' Home, 2340 Clay Street

THURSDAY AFTERNOON—OCTOBER 18, 1945

1:30—5:00 P.M.

Stanford University Medical School

Stanford Hospital—Lane Hall

J. Marion Read, M.D., Presiding

1:30 P.M.

Clinical Pathological Conference—Samuel A.  
Levine, M.D. and Alvin Cox, M.D.

2:30 P.M.

Problems in Penicillin Treatment of Subacute Bacterial  
Endocarditis—Arthur L. Bloomfield, M.D.

3:00 P.M.

Importance of Myocardial Infarction in Subacute  
Bacterial Endocarditis—Clarence Tinsley, M.D.

3:30 P.M.

Pathological Results in Bacterial Endocarditis Treated  
with Penicillin—William H. Carnes, M.D.

4:00 P.M.

The Present Status of Anti-Coagulants in the Treatment  
of Cardiovascular Disease—Col. Irving S. Wright, MC

FRIDAY MORNING—OCTOBER 19, 1945

9:00 A.M.—12:00 Noon

University of California Hospital—Toland Hall

Third and Parnassus Avenues

Leslie L. Bennett, M.D., Presiding

9:00 A.M.

Obstruction of the Aorta—with Presentation of Cases—  
William J. Kerr, M.D.

9:30 A.M.

Heart Disease in Soldiers—Gordon E. Hein, M.D.

10:00 A.M.

Tuberculosis and Heart Disease—James J. Waring, M.D.

10:30 A.M.

Recess

10:40 A.M.

Smithwick Splanchnicectomy in the Treatment of  
Hypertension: Comparison with the Peet Procedure

Howard C. Naffziger, M.D., and

Francis L. Chamberlain, M.D.

11:10 A.M.

Differential Diagnosis of Neurovascular Syndromes of  
the Shoulder Girdle—Col. Irving S. Wright, MC

12:00 M.—1:30 P.M.

Box luncheons will be available in Room 100 of the  
Pharmacy Building—Parnassus and First Avenues

FRIDAY AFTERNOON—OCTOBER 19, 1945

University of California Hospital—Toland Hall

William J. Kerr, Presiding

1:30 P.M.

The Surgical Risk of Heart Disease—

William H. Gordon, M.D.

2:10 P.M.

Atypical Angina—Eliot Sorsky, M.D.

2:50 P.M.

Demonstration of Electrocardiograms of Autopsied  
Patients—Francis L. Chamberlain, M.D.

3:50 P.M.

Recess

4:00 P.M.

General Discussion—Questions and Answers—  
Samuel A. Levine, M.D.

FRIDAY EVENING—OCTOBER 19, 1945

7:00 P.M.

Sixteenth Annual Dinner Meeting

Colonial Ballroom—St. Francis Hotel

David A. Ryland, M.D., Chairman, Presiding

The Treatment of Congestive Heart Failure—

Samuel A. Levine, M.D.

SATURDAY MORNING—OCTOBER 20, 1945

9:00 A.M.—12:00 Noon

San Francisco Hospital

Potrero Avenue and Twenty-second Street  
Report at Main Entrance of Hospital and Proceed to

Solarium of Ward 2  
Charles A. Noble, Jr., M.D. and  
Clarence M. Tinsley, M.D., Presiding  
Clinical Demonstrations of Various Types of  
Heart Disease

### University of California School of Public Health

The School of Public Health of the University of California has announced the appointment of four new faculty members. Dr. W. McDowell Hammon became Associate Professor of Epidemiology in the School of Public Health. He will be responsible for developing the training programs in epidemiology, and will continue to serve the University as Associate Professor of Epidemiology in Hooper Foundation.

Dr. Richard A. Bolt has been appointed Visiting Professor in Public Health. Dr. Bolt has been one of the leaders in the development of the child hygiene movement in America. Recently he retired as Director of the Cleveland Child Health Association and as a member of the faculty of the Department of Public Health and Pediatrics at Western Reserve University.

Dr. Clair E. Turner, formerly professor of biology and public health at Massachusetts Institute of Technology, and recently chief health education officer of the Coordinator of Inter-American Affairs, has been appointed Visiting Professor of Health Education and will begin his duties with the opening of the autumn semester.

Mr. Walter S. Mangold has been appointed Associate Professor of Sanitary Practice. Mr. Mangold is nationally known as a consultant in the field of Sanitary practice. He will be responsible for the development of the post-war program for training sanitarians in the School of Public Health.

For announcement of the School of Public Health of the University of California, Walter H. Brown, M.D., Acting Dean, address: U. C. School of Public Health, 3583 Life Sciences Building, Berkeley, California.

### Medical Films Available for Component County Medical Societies of C.M.A.

The Committee on Postgraduate Activities of the California Medical Association has purchased 17 medical films. List of titles and time to run appears below.

Letters giving information concerning procedure for use of these films have been sent to the presidents and secretaries of all C.M.A. county societies.

The films are also available for branch or specialist sections of larger county units.

Films will be serviced and kept in good condition by Castle Distributors Corporation, 943 Russ Building, San Francisco.

Requests for films should be sent to C.M.A. Postgraduate Committee, c/o George H. Kress, M.D., Secretary, 450 Sutter Street, Room 2004, San Francisco (8).

All films are "silents," that is, with explanatory legends. List follows:

Filing Number of Film	Title of Film	Running Time Single Film	Total Time for Sequence
1—Acute Appendicitis (Professional)			
Reel I		15 Min.	} 2 Reels 31 Min.
2—Acute Appendicitis (Professional)			
Reel II		16 Min.	
3—Benign Prostatic Hypertrophy		17 Min.	
4—Cardiac Irregularities—Reel I		17 Min.	} 2 Reels 34 Min.
5—Cardiac Irregularities—Reel II		17 Min.	
6—Infections of the Hand—Reel I		17 Min.	} 3 Reels 48 Min.
7—Infections of the Hand—Reel II		17 Min.	
8—Infections of the Hand—Reel III		14 Min.	

9—Indirect Inguinal Hernia—Reel I	16 Min.	} 3 Reels 41 Min.
10—Indirect Inguinal Hernia—Reel II	10 Min.	
11—Indirect Inguinal Hernia—Reel III	15 Min.	

12—Intestinal Peristalsis	16 Min.
13—Normal Heart	10 Min.
14—Rabies	8 Min.
15—Simple Goiter	17 Min.

16—Treatment of Normal Breech		
Presentation—Reel I	15 Min.	} 2 Reels 29 Min.
17—Treatment of Normal Breech		
Presentation—Reel II	14 Min.	

## COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

### Health Lecture Series to Physicians and Public Opened on Friday, October 12

The fall public relations program of the Los Angeles County Medical Association opened with a series of public health talks to be presented in the Lodge Room of the Elks Temple, at 607 South Park View Street, Los Angeles, on Friday evening, October 12, at 8 o'clock. The program for the six meetings to be held on consecutive Friday nights appears below:

#### PROGRAMS—HEALTH LECTURE SERIES

PLACE: Lodge Room, Elks Temple, 607 South Park View  
Friday Evening, October 12, at 8:00 p.m.

#### "PENICILLIN—THE LIFE SAVING MIRACLE"

1. Address of Welcome.... Jay J. Crane, M.D., President, Los Angeles County Medical Association.
2. Introduction of Doctors George H. Uhl and H. O. Swartout, City and County Health Officers.
3. Three Addresses on Penicillin by
  - a. J. Norton Nichols, M.D.
  - b. James C. Doyle, M.D.
  - c. Paul M. Hamilton, M.D.

Friday Evening, October 19, at 8:00 p.m.

#### THE TRUTH ABOUT VENEREAL DISEASES

1. Education and Venereal Diseases..... Mr. David Ell Janison, Director, Public Health Information, Los Angeles City Department of Health.
2. The Venereal Diseases.... E. M. Fainer, M.D., Director Men's Venereal Disease Clinic, Los Angeles City Department of Health.
3. Venereal Disease Control Highlights..... Herbert H. Cowper, M.D., Director, Venereal Disease Control Division, Los Angeles City Department of Health.

Friday Evening, October 26, at 8:00 p.m.

#### PREVENTIVE MEDICINE

1. Industrial Health.... Hugh Dierker, M.D., Los Angeles County Health Department.
2. Disease Problems in a War-Torn World.... Norman B. Nelson, M.D., Director, Division of Communicable Diseases, Los Angeles City Department of Health.
3. Tuberculosis, Cancer and Heart Disease.....

J. M. de los Reyes, M.D.  
Friday Evening, November 2, at 8:00 p.m.

#### MODERN SURGERY—Three Addresses by

E. Vincent Askey, M.D.  
(Speaker to be Announced Later)  
L. A. Alesen, M.D.

FIRST HUNDRED YEARS OF ANESTHESIA.....  
Arthur E. Guedel, M.D.  
Friday Evening, November 9, at 8:00 p.m.

#### GIFTS OF MODERN MEDICINE

1. The Story of Medicine and Its Place Today.....
2. Medical Specialties..... T. T. Remmen, M.D.
3. The Female Hormones..... Clifford A. Wright, M.D.

Friday Evening, November 16, at 8:00 p.m.

#### BLESSED EVENTS

1. What Price Baby?.. William Benbow Thompson, M.D.
2. New Baby Health Insurance..... Harold K. Marshall, M.D.
3. Why a Cesarean Section?... Donald G. Tollefson, M.D.

The Los Angeles County Committee on Public Relations and the Executive Committee began working on this series of talks early in the summer. The City and County Health Departments are coöperating in making these programs of real value to the people of this area.

Shortly after plans for the series got under way, the Council of the California Medical Association was approached with the thought that if these programs could be put on in the various component county medical associations throughout the State the same evenings they were being presented in Los Angeles a very well worth while cumulative result in public relations would be obtained. The Council of the California Medical Association accepted this proposal and county medical associations in California are being asked to present similar programs.

The Los Angeles County Medical Association has sent to the California Medical Association sufficient mimeographed copies of all talks to be presented in Los Angeles, these talks to be of suggestive value to the officers of the various county associations in the arranging of their programs.

State-wide publicity will be achieved by the Public Relations Department of the California Medical Association to insure good audiences. The publicity program here in Los Angeles, which will be supported by the State publicity, will depend very largely upon members of the Association and members of the Woman's Auxiliary. Publicity also will be obtained via the radio and by means of newspaper publicity. The newspaper publicity campaign will be greatly augmented by the Public Health Educational Division of the Los Angeles City Health Department.

Members of the Association are now asked to inform their patients of this series of public health lectures and to tell their friends and acquaintances about it. Members are asked to spread the word of this public health program in every way they possibly can.

Remember, the series opens on Friday evening, October 12, at 8:00 o'clock, in the big Lodge Room of the Elks Temple, 607 South Park View. Of course, there is no admission charge. Everyone interested is cordially invited. Members are invited to come with their friends.

The subjects selected for the six evenings were given a great deal of consideration. Especially considered was the interest of the public in these subjects. The talks will be largely augmented by illustrations and motion pictures.

A great deal of work has gone into this public relations endeavor. Its real success now depends to a great extent upon each member in spreading the word about it. You will be safe in telling your friends and patients that these talks will not only be highly educational but exceedingly interesting. Tell them not to be reticent in inviting their friends to come with them. Everyone is welcome.

### Facts on Use of DDT

#### *An Insecticide, with Toxic Properties*

Since the proper use of DDT requires special knowledge and training, a bulletin has been published as a technical guide for the Army to its safe and efficient use, Major General Norman T. Kirk, Surgeon General of the Army, recently announced. The publication contains information on the precautions to be taken in handling DDT, its mode of action in insect control, and the proper methods of application of the DDT insecticide items issued by the Army.

It is emphasized that, although DDT may be safely handled as an insecticide, it is, nevertheless, a toxic material. Poisoning may occur from ingestion of DDT or by absorption of DDT solutions through the skin. DDT powder and areosols are not absorbed through the skin, and have been found to produce no ill effects when inhaled in small amounts. However, in conditions where air currents do not carry away the dust from the user, it is wise to wear suitable respirators as protection against excessive inhalation.

DDT acts on insects both as a contact poison and as a stomach poison. Studies have shown that the poisonous effect of DDT on mosquito larvae is fully as powerful as that on the adult insect, although on some other insects, such as flies, the larvae are not equally affected by the insecticide. In applying DDT as a mosquito larvicide to open water receptacles, a prolonged effect may be obtained because of the residual action of the chemical. However, in applying it to natural water bodies the effect is much shorter, due to the binding action of mud in the water, which apparently checks the effectiveness of DDT. It should also be considered that amounts of DDT greater than 0.2 pound per acre may prove fatal to fish and wild life. For extermination of insects such as ants, roaches, fleas, bedbugs and flies, DDT oil solution or powder should be used, with particular attention to cracks, holes, and seams in walls, floors, and bedding, as indicated. One of the most valuable characteristics of DDT lies in its tendency to remain deadly to insects over a prolonged period of time. In applying DDT solutions to walls and other large surface areas, a coarse spray is usually employed, but in applying it to screens or mesh surfaces, ordinary paint brushes may be used. Although the effectiveness of the treated areas against insects persists for some time, the insects which come in contact with the chemical may not die until an hour or more has elapsed, and immediate death should not be expected.

When applying solutions of DDT in kerosene, precautions concerning the inflammability of the kerosene should be observed. Care should be taken to keep electric motors and other sparking or heating apparatus from the zone of spray. No open fires or smoking should be permitted until the spray has dried and ventilation is complete. The kerosene in the solution is harmful to rubber equipment and may cause a mild skin irritation when in contact with the skin.

Thanks to the magic properties of DDT, many lives have been saved in this war and much disease prevented. Extermination of disease-carrying insects has reduced the incidence of typhus, malaria, and other ravaging diseases of the war areas.

Although rapid progress has been made in the development of DDT since it first made its appearance in the field of science, much remains to be learned before its full potentialities in insect control can be realized. Signs of progress are evident in the spraying of large areas by aircraft, the mass delousing of communities in Europe, and the better methods of manufacture. Investigation is continuing on every aspect of DDT, however, in search of new and extensive improvements in everything from its chemical beginning to its final application in the field.

### Improvement in Health of the Nation

Improvement in the health of the nation sufficient to save many thousands of lives annually is seen as probable for the early postwar years by the medical men in the life insurance business, the Institute of Life Insurance recently announced.

"General application to the population as a whole of the many revolutionary discoveries of the war period, up

to now largely used for members of the armed forces, is expected to be an important factor contributing to the reduction of mortality," the Institute reported. "In addition, the extension of medical research on a greater scale should hasten the discovery of controls in certain diseases which remain as major causes of the country's deaths."

Among the wartime health discoveries or activities which may benefit the population as a whole in the future are: revolutionary use of blood plasma; discovery of penicillin; extension of the use of the sulfa drugs; DDT for control of germ bearing insects; military research on both curative and preventive medicine; successful inoculation against typhus; new advances in plastic surgery; use of mobile x-ray, operating, optical and dental units; uses of blood's by-products such as red corpuscle transfusions for anemia, fibrin film as substitute brain covering, serum albumin for wound shock, fibrin's foam as a blood-clotter in nerve surgery, fibrin's use as a glue in skin-grafting, use of red corpuscles to paint wounds and reduce inflammation.

These are only a few of the many surgery and drug discoveries which have contributed to reducing the death rate of wounded to 3 per cent in the present army, compared with 8.1 per cent in World War I. At the same time, the Army death rate from disease has been reduced to one-third that of civilians of the same group types, in spite of the greater hazards among the military, especially in overseas service.

The extent to which health progress can be made is indicated by the experience among life insurance policyholders over the past fifteen years. The three-year average death rate among civilian policyholders for the years 1942-1944 is about 20 per cent lower than the three-year average for 1927-1929. "The significance of this progress becomes clear when translated to policyholder lives saved per year," the Institute continued. "It would indicate, for instance, that in 1945, barring unforeseen circumstances, there should be 100,000 fewer civilian policyholder deaths than there would have been had the death rate of fifteen years ago still applied. Going back to 1900, we find that 1945 will probably see at least 350,000 fewer civilian policyholder deaths than would have occurred under the death rate of 45 years ago.

About 75 per cent of all the savings in lives since 1929 has been accounted for by just the reduction in death rate from tuberculosis, typhoid, influenza and pneumonia. The ravages of these four diseases alone have been so checked by the intensive efforts of recent years that in 1945 they will probably cause at least 75,000 fewer deaths among policyholders than they would on the basis of 1929 death rates. The reductions in the annual death rates from the 1927-29 level to the 1942-44 level were as follows: tuberculosis, 55 per cent; typhoid, 90 per cent; influenza, 80 per cent; pneumonia, 60 per cent.

Great strides have also been made in the reduction of deaths among children. The infant death rate has been cut in half in the same fifteen-year period and deaths from the children's diseases of diphtheria, whooping cough, scarlet fever and measles have been reduced to almost one-tenth the 1929 rate.

#### Life Expectancy

One of the larger life insurance companies reports the wartime and the prewar period—so far as overall conditions are concerned—were beneficial to the health of American United States civilians.

Despite restrictions involving curtailed diet, unfavorable housing conditions, lack of normal medical facilities and similar emergency factors, the life expectancy of company policyholders was 64.40 years at the beginning of 1945 as against a full year less in 1941.

The expectation of life of the insured group, based on mortality records, also was a half year shorter in 1943 than last year.

The comparisons exclude military and civilian deaths caused by enemy action, of course, but they emphasize two points. As the insurance company statisticians explain, wartime hardships

have not been severe enough to offset the advantages secured by the high standards of living in the prior years of peace (and) not all our people have undergone these hardships—a goodly number actually have been able to advance their standard of life as a result of widespread full employment.

#### Dr. Parran Maps Six Point Health Program for All Citizens

A six point program to provide "equal health opportunities for every citizen" was outlined by Surgeon General Thomas Parran of the U. S. Public Health Service at the 122nd opening session of George Washington University School of Medicine. He was guest of honor at a luncheon given by Dr. Walter A. Bloedorn, dean of the school, at the Mayflower, attended by Army, Navy and District medical leaders. Dr. Parran's program called for

(1) an integrated system of hospitals and health centers radiating from a central unit to smaller local and rural communities;

(2) sanitary environment, covering water, milk, food and sewage, which would eradicate such diseases as malaria;

(3) intensified preventive disease programs, including expanded cancer control, dental, nutrition and nursing programs;

(4) expanded medical research;

(5) training of engineers, nurses, technicians and research workers, as well as doctors, to man postwar health armies;

(6) health insurance and medical care, as provided in such legislation as the Wagner-Murray-Dingell bill and the Miller bill. Dr. Parran said that 121 bills coming up in the 79th Congress would cover his six point program.—*A.M.A. Washington Letter.*

#### Randolph Health Bill for Federal Employees Considered Again

The House Rules Committee has cleared the way for consideration on the House floor of the Randolph health bill for government employees. An hour's debate was ordered. The health bill, sponsored by Representative Jennings Randolph, Democrat of West Virginia, provides for setting up employee health program, including clinics in various government departments, at the direction of department heads. It would be part of a general program, to promote physical and mental fitness of government employees such as is now carried out by a large number of business organizations.

#### Basal Temperature Records to Aid Infertility Treatment

A basal temperature record to aid in determining the probable time of ovulation in individual women is being made available by the Medical Committee of the Planned Parenthood Federation of America to physicians interested in the treatment of infertility and the planning of conception.

As reported by Dr. Pendleton Tompkins in the issue of March 11, 1944, of the *Journal of the American Medical Association* (Vol. 124:697-700), it has been found

that an accurate daily record of basal temperature is valuable in estimating the optimum time for conception.

There is a slight rhythm of variation in the normal temperature of a healthy woman—the temperature being lower during the first half of the menstrual cycle than during the later half. The transition from the lower level to the higher one occurs at about the time of ovulation. In many cases the temperature will show a sharp drop and then shoot immediately to the higher level which can be taken as an indication that ovulation is taking place. As the variation for the entire cycle may be less than half a degree, the patient must be provided with complete instructions and forms with which to plot her temperature accurately. The temperature is taken rectally each morning immediately upon awaking before the patient has gotten out of bed, talked, eaten, drunk or smoked.

The charts, as provided by the Planned Parenthood Federation, provide for a six months' record. They indicate the calendar months, the length of the individual cycle and the number of days backward from the onset of the menses at which ovulation can be estimated to occur.

The charts, together with the instruction forms for patient use, are available at cost through the Medical Department, Planned Parenthood Federation of America, Inc., 501 Madison Avenue, New York 22, N. Y.

### Conclusions From a Study of 7 Million Births

From a study of the live births and stillbirths of more than 7,000,000 American babies in the five years from 1937 to 1941, came important evidence in support of the child-spacing theory. This is the now commonly held medical opinion that each mother needs a period of rest and recuperation between the birth of one child and the beginning of another pregnancy.

Dr. Jacob Yerushalmy, principal statistician in the United States Public Health Service, has found that the amount of time between pregnancies has an important relationship to the possibility that reproduction will end in the tragedy of a stillbirth. More than 75,000 American babies are lost each year through stillbirths.

Precisely how long the average space between births should be to reduce the danger of stillbirth to a minimum, Dr. Yerushalmy was unable to indicate from his findings. He did conclude, however, that "relatively short intervals (between pregnancies) and relatively long intervals are associated with higher stillbirth rates while moderate intervals lead to the lowest rates."

The results of his study appeared in detail in the last issue of *Human Biology*.

### Victory Over Disease

One highly significant statement was that recently from Army Medical Corps sources to the effect that, for the first time in the history of war in Europe, more men were admitted to American theater hospitals for treatment of battle wounds than for diseases. The same fortunate situation seems to have existed in the Pacific as well.

The amazing record for the American forces doubtless has been due, in some degree, to the fact that Uncle Sam's fighting men, taken as a whole, were the healthiest ever to be sent into battle.

But, beyond any question, the most important factors were the safeguards taken to protect the health of our soldiers and sailors. Never in any war has any nation given such vigorous and intelligent attention to the prevention of diseases—particularly germ diseases of the type which have little or no respect for natural resistance. This was a protection provided through such expedients as destruction of vermin and the provision of opportunity

for uncontaminated drinking water. No one knows how many men were saved from sickness or death through such measures, but certainly the number totaled in the many, many thousands.

And, if war can be productive of blessings, the experience gained in the prevention and treatment of diseases surely is one of them. It is a blessing which will be with us in peace, as well as in war. It undoubtedly will mean longer and healthier lives for people today and for all generations to come. It represents a victory no less important than any gained upon the fields of battle.

### On Venereal Disease Control

A "chaotic condition" for control of venereal disease recently was predicted for San Francisco during the next one and one-half years.

Dr. Richard A. Koch, chief of the city's venereal diseases division, said that with the lifting of strict wartime measures which kept the control program just holding the line for the past four years, the number of cases would no doubt far exceed the 700-a-month now being treated, at least until the city settles down to a peacetime status.

He said he feared the results of an increasing concentration of Army and Navy personnel in this area who would be "out for a good time" now the war was over and military and Federal social welfare supervision relaxed. The consequences of the three-day victory "celebration" would also mean a sharp rise in venereal disease, he was sure.

Dr. Koch quoted the report of Dr. Carl Buck of the American Medical Association, who made an independent survey of San Francisco's postwar health program. Dr. Buck said he "hoped San Francisco would not make the fatal mistake of so many communities after the last World War in abandoning or curtailing venereal disease control services."

Dr. Buck has recommended that San Francisco's "present program of venereal disease control be continued as a necessary means of preventing the personal and economic losses which would otherwise result."

Records kept by the department of health on venereal disease from before Pearl Harbor show an average of 206 total (military and civilian) cases a month in February, 1941, which climbed steadily until it is now in 1945, over the 700-a-month mark.

While military cases have shown a decided increase over these years, the incidence of the diseases among civilians has remained fairly steady. By the end of 1944 there were only 30 more cases being found a month among civilians.

### 6,000 Wartime Cases

A total of more than 6,000 cases were turned up during the war years in San Francisco among military and civilians.

Dr. Koch lists the contributing factors in the increased venereal disease load as:

1. The large increase in civilian population, particularly population groups with high v.d. rates.
2. The large increase in military population.
3. Increased social and moral problems created by war.
4. Better case reporting from the military and civilian treatment agencies as well as from private physicians.
5. Broad v.d. education and case-finding programs have increased public awareness for proper medical treatment and decreased "quack" practices.
6. Increased staff of Public Health nurses and male investigator for infectious case follow-up.

With the help of the Health Department and the Social Hygiene Association there is at the present time a social

awareness of the venereal disease hazard in industry which didn't exist three years ago.

In the last 14 months the San Francisco Health Department has done 34,054 blood tests on local industrial workers; 3,354 of these workers were found to have a positive blood test—and 80 per cent of these had syphilis, with 50 per cent of them unaware of their infection, Dr. Koch said.

### Federal Appropriations For VD Control and Social Protection

Passage on June 30 of the Labor-Federal Security Appropriations Bill (H.R. 3199, now Public Law 124, 79th Congress) for the fiscal year ending June 30, 1946, and approval by President Harry S. Truman on July 3, assures continuance for the eighth consecutive year of Federal aid to states for VD control through the U. S. Public Health Service, and continues for its fifth year the Social Protection Division of the Federal Security Agency.

The appropriation to U. S. Public Health Service for the coming year, to carry out the purposes of the La-Follette-Bulwinkle VD Control Act of 1938, including aid to states, is \$11,949,000. The decrease from the approximate \$12,500,000 for each of the past three years is accounted for primarily by reduction in overtime pay, in accordance with recent Congressional action; by reduction in personnel in unclassified positions who have been taken over by the states and put on state payrolls; and the lower cost of penicillin.

The Rapid Treatment Center program, formerly administered Federally by the Federal Works Agency, is turned over to the USPHS by this Bill; and \$4,644,000 is provided for maintenance and operation.

### Venereal Disease Facts—Los Angeles City

1. Estimates based on current attack rates indicate that there exist in Los Angeles 72,520 individuals who now have or have had syphilis. This is a minimum figure.

2. There is a good possibility that there exists an equal number of persons who have syphilis but have no knowledge of their disease. Of the 72,520 who are presumably unaware of their infection, 18,000 are potential candidates for brain, spinal cord, or cardiac syphilis.

3. A child born in Los Angeles City and living under current conditions, has a better than 1 in 15 chance of acquiring syphilis before he attains the age of 45. This again is a minimum figure based on actual reported cases and adjusted for age, race, and sex.

4. The attack rate for syphilis in the city was 65 in 1943, and 101.6 in 1944.

5. The attack rate for gonorrhea was 265 in 1943, and 374 in 1944.

6. In 1944 there were 1,142 reported cases of new venereal disease infections in the 15-to-19-years age group. This represents a 28 per cent increase over 1943.

7. The venereal disease attack rate in the 15-to-19 age group, based on reported cases, has increased 120 per cent since 1939.

8. In 1944 the attack rate for syphilis in the State of California was 50; in Los Angeles City it was 101.6.

9. A total of 40.8 per cent of all syphilis and 30 per cent of all gonorrhea reports in California originate in Los Angeles City.

10. So far in 1945, 11,666 cases of venereal disease have been reported in this city.

11. The syphilis rate, in infants under 1 year of age, per 1,000 live births increased from 0.52 in 1943 to 1.12 in 1944.

It would be of interest to have similar statistics for other cities in California.

### Care of the Eyes

The Health Committee of the Chamber of Commerce of the United States, Washington, D. C., through its Health Advisory Council, recently sent out the following bulletin on "Do's and Don'ts" for eye health:

Do provide proper lighting—without shadows or glare—in the home, school, office, and shop—to avoid eye strain.

Do rest the eyes occasionally by closing them or by looking at distant objects.

Do protect the eyes of infants from exposure to direct sunlight or bright artificial light, and from toys with points or sharp edges.

Do have your child's eyes examined before he enters school and regularly thereafter.

Do have your own eyes examined regularly.

Do consult a competent specialist regarding correction of eye defects, including muscle imbalance, squint, cross eyes, nearsightedness, farsightedness, and blurred vision, and for injured, painful, sore, or diseased eyes.

Do protect your eyes with a shield or goggles of good quality if you work where your eyes are exposed to electric arc rays or sparks, to splashing chemicals, or to flying particles of dust, sand, or metal.

Do not rub your eyes with fingers or soiled handkerchiefs—to do so may rub germs into your eyes.

Do not use towels or wash cloths used by others—they may cause serious eye infections and blindness.

Do not wear colored glasses unless you need them under special circumstances; do not wear colored glasses of inferior quality under any circumstances.

Do not try to diagnose or treat your own eye troubles, and do not wear glasses already made up and sold or displayed on store counters.

Call a doctor immediately if simple measures fail to remove a foreign body in the eye; do not rub the eye—to do so may drive the foreign body deeper into the tissues of the eye and damage or infect the eye.

To remove foreign body, grasp lashes of upper lid and pull down over lower lid and then release so that tears may wash foreign body to inside corner of eye where it can be removed easily with corner of sterile bandage—or flush the eye thoroughly with clean, cool water.

Chemicals in the eyes, such as acids, caustics, lime, plaster, cement, etc., should be washed down the eye immediately with very large and repeated quantities of clean cool water before the doctor comes.

### Texas Sets Insurance Plan Principles

Six Principles adopted by the Council on Medical Economics of the State Medical Association of Texas, for guidance in the evaluation of plans and policies offered in the distribution of medical and surgical service:

1. Insurance companies should be solvent.

2. Nonprofit insurance companies shall be as nearly nonprofit as is consistent with sound business principles and practices.

3. Insurance companies should avoid advising subscribers to consult any certain doctor or doctors. In general policies should conform to the usages of medical ethics, and specifically there should be free choice of doctors, and no interference with the traditional doctor and patient relationship.

4. Insurance companies should cause to be stated on the face of their policies that the amount allowed in the policy for medical care does not necessarily cover the charges of the doctor for his services.

5. Insurance companies should not provide payments to any hospital, or hospitals for the services rendered the insured by any doctor.

6. It should be recognized that insurance companies are at the present time forced to feel their way in hospital and sickness insurance, and that changes in plans and procedures may be necessary for several years.

*Robert Burns (1759-1796).*—Privation, exposure, and overwork in adolescence predisposed Robert Burns to rheumatic infection and endocarditis. At one time, undertaking a self-cure for spells of dizziness, he kept a tub of cold water beside his bed into which he would plunge when faint. There are those who would attribute his early death to alcoholism, but many find it difficult to believe that the imperishable songs and ballads of this most beloved of Scottish poets are compatible with a life of dissipation.—*Warner's Calendar of Medical History.*

## MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

### NEWS

#### Coming Meetings†

**California Medical Association.** Session will convene in Los Angeles. Dates of the seventy-fifth annual session, to be held in 1946, will be announced later.

**American Medical Association.** The A.M.A. House of Delegates will convene in Chicago, Dec. 3-6, 1945. (See J.A.M.A., Sept. 22, 1945.)

#### The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick or proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Ed. Note.—Interpretative comments or principles included in the A.M.A. platform appear in CALIFORNIA AND WESTERN MEDICINE for December, 1939, on pages 394-395. For subsequent comment, see J.A.M.A., June 24, 1944, pp. 574-576. See also C. AND W. M. for August, 1945, pp. 61-62.)

#### Medical Broadcasts\*

**The Los Angeles County Medical Association:**

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays:

KFAC presents the Saturday programs at 10:15 a.m., under the title, "Your Doctor and You."

In August, KFAC will present these broadcasts on the following Saturdays: August 4, 11, 18, and 25.

The Saturday broadcasts of KFI are given at 9:45 a.m., under the title, "The Road to Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association is on the air each Saturday at 1:30 p.m., Pacific War Time.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

\* County societies giving medical broadcasts are requested to send information as soon as arranged.

#### Pharmacological Items of Potential Interest to Clinicians:

1. *Where now, Big Boy?* The *New Yorker*, as usual avoiding clichés, does well on atomic energy, especially with profile of N. Y. Timesman W. L. Laurence, stimulating science writer (*New Yorker*, Aug. 18, p. 26). Psychology of surrender is well discussed by T. Draper in August *Atlantic*, p. 62. For atomic energy, the fundamental equation is Einstein's  $E$  equals  $Mc^2$ , where  $c$  is the velocity of light ( $3 \times 10^{10}$  cm/sec) (*The Meaning of Relativity*, 2nd Ed., 1945, 135 pp., Princeton Press, \$2). And for this brave new world there is also J. von Neumann and Morgenstern's *Theory of Games and Economic Behavior* (Princeton Press, 1945, 644 pp., \$10), and G. Polva's *How to Solve It* (Princeton Press, 1945, 220 pp., \$2.50).

2. *Symposia and Reviews:* S. Warren, B. E. Hall & Co. give neat symposium on radioactive phosphorus in leukemia and polycythemia (*Am. J. Med. Sci.*, 209:707-717, 1945). Note abstract symposium on effects of centrifugal force on animals and man (*J. Physiol.*, 104: Proc. 5-12, June, 1945). Neuropsychiatry symposium (*Brit. Med. Bull.*, 3:1-64, 1945), contains F. M. R. Walshe's account of Queen Square neurology classics and D. Williams clinical application of electroencephalography. Also note symposium on wound healing, burns and shock (*Brit. Med. Bull.*, 3:70-119, 1945). C. B. Friedman reviews pathology of trench foot (*Am. J. Path.*, 21:387, 1945). B. H. Kean and R. G. Grocott review sarcosporidiosis (*Am. J. Path.*, 21:467, 1945). W. J. Tompkinson reviews chronic toxoplasmosis (*J. Clin. Path.*, 15:123, 1945). E. J. Conway analyses physiological significance of inorganic levels in internal medium of mammals (*Biol. Rev. Cambridge Philo. Soc.*, 20:56, 1945). J. Sinclair calls attention to helpful symposium on genes as physiological agents (*Am. Naturalist*, 29:289-363, 1945). G. Wald reviews human vision and the spectrum (*Science*, 101:653, June 29, 1945). P. Levine reviews Hr factor and Rh genetic theory (*Ibid.*, 102:1, July 6, 1945). R. F. Pitts reviews renal regulation of acid base balance (*Ibid.*, 102:54, 81, July 20 and 27, 1945). And *Annual Reviews and Physiological Reviews* continue well: J. H. Burn discusses epinephrin and acetylcholin in nervous system; H. F. Blum surveys sunlight effects, and H. N. Harkins reviews burns (*Physiol. Rev.*, 25:377, 483, 531, 1945).

3. *Therapeutics:* R. A. Peters & Co. find cysteine and methionine useful in recovery from postarsphenamine jaundice (*Quart. J. Med.*, 14 ns: 35, 1945). F. Proescher's acridine-sulfa compounds are finally exploited as wound antiseptics by J. McIntosh & Co. (*Lancet*, 2:97, July 28, 1945). A. M. da Cunha & Co. find penicillin effective in yaws (*Mem. Inst. Oswaldo Cruz.*, 41:247, 1945). C. P. G. Wakerley and G. Blum (Berlin M.D.), find UFI, compound of urea and iodine, is helpful when powdered on wounds (*Lancet*, 2:42, July 14, 1945). A. Meyer and D. Teare report case of fat embolism following electrical convulsion therapy (*BMJ*, 2:43, July 14, 1945). F. Himmelweit notes bacteriophage aid in antibiotic action of penicillin against resistant organisms (*Lancet*, 2:104, July 28, 1945). G. C. Linder suggests

\* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

blood phosphatase as index to dosage of estrogen in prostatic disease (*Clin. Proc., Cape Town P.G. Med. Asso.*, 4:64, 1945). H. F. Shaw indicates value of approach to therapeutics through mode of action of drugs on cells in Blakian style (*Med. J. Austral.*, 1:649, June 30, 1945). V. P. Filatov reports on tissue therapy in cutaneous leishmaniasis (*Am. Rev. Sov. Med.*, 2:484, 1945).

4. *Odds and:* C. Sutherland offers evidence that house-dust allergen is polysaccharide (*Med. J. Austral.*, 1:583, June 9, 1945). J. Muniz and G. de Freitas report successful complement fixation diagnostic test for Chagas disease (*Mem. Inst. Oswaldo Cruz*, 41:303, 1944). S. Rose and D. Rabinov report experimental success of electrical anesthesia (*Med. J. Austral.*, 1:657, June 30, 1945). S. Sarkisov (Moscow Brain Inst.), discusses new developments in brain morphophysiology (*Brit. Med. J.*, 2:37, July 14, 1945). W. Feldberg and T. Mann (*J. Physiol.*, 104:8, 1945), confirm D. Nachmansohn and A. L. Machado (*J. Neurophysiol.*, 6:397, 1945), that brain synthesizes acetylcholine anaerobically in presence of adenosinetriphosphate and choline, and add that reduced glutathione and cysteine strongly activate aerobic formation, with inhibition by sugars and Ca, and stimulation by K. E. C. Dodds & Co. (*J. Physiol.*, 104:47-51, 1945), fail to confirm H. G. Wolff & Co. (*J. Clin. Invest.*, 20:63, 1941), that morphine raises pain threshold to heat in man, and report no significant analgesia from diphenylethylamine, although it gives incoördination. B. Benesch shows synthesis of nicotinic acid in human caecum under aerobic conditions and destruction under anaerobic (*Lancet*, 1:718, June 9, 1945).

P.S. B. de Voto's comments on University of Texas in August *Harper's* derive from H. P. Rainey; like those in *PM* and *Collier's* they are neither inclusive nor conclusive.

**Two-thirds of San Francisco War Chest for Health Welfare.**—Two-thirds of the \$3,950,000 sought in the San Francisco War Chest October drive will go to local health and welfare agencies.

Seventy hospitals, clinics, youth agencies, children's institutions and homes for the aged-ill are scheduled to receive \$2,432,003.

Of the remainder \$831,428 would go to the U.S.O. and the United Seamen's Service and \$531,569 to 16 national and international war relief agencies.

#### State Bar to Aid Military Veteran Attorneys.

More than 2,500 lawyer veterans will be assisted in returning to their civilian practices by the State Bar of California, which has organized a placement service, refresher courses, advisory and welcoming committees.

Judge Roger Traynor, Leigh Athearn, Thomas H. Kennedy, Eugene M. Prince and Joseph C. Sharp of San Francisco, and Harold Huovinen of Oakland have been appointed members of a committee in charge of the placement service headed by Chairman Herbert Freston of Los Angeles.

Dean Edwin J. Owens and John H. Riordan are San Francisco members of the educational committee which has planned a series of lectures to be given in the San Francisco-Sacramento and Los Angeles-San Diego metropolitan areas.

#### Examination for Chief, Bureau of Tuberculosis.

The duration examination for Chief, California Bureau of Tuberculosis, originally scheduled for September 13, 1945, has been postponed to November 22, 1945. The final date for filing applications has been extended to November 8, 1945.

In accordance with the provisions of Section 18901 of the Government Code, any list of eligibles resulting from

this examination "will expire not less than one but less than four years after adoption of such list." The State Personnel Board may remove all names from such eligible lists at any time after they have remained thereon for more than one year from the date of adoption and will remove all names from such lists not later than four years after adoption.

This examination is a *duration* examination, held under Section 19200 of the Government Code to provide a duration open eligible list. Eligibility resulting from this examination and appointments made from the resulting eligible list will expire not later than 90 days after the Governor finds and proclaims that the present emergency no longer exists. However, employment under duration appointments will count toward seniority, sick leave, and vacation credits and will constitute qualifying experience for entrance to examinations when appropriate.

**Goldschmidt Writes Book on Mutation.**—Sudden hereditary changes, mutations—which produce offspring different from any of their ancestors, are caused by stresses inside the germ cell which result in rearrangements of the chromatin, nuclear material of the cell. This belief, supported by voluminous genetic data, is embodied in a volume by Dr. Richard Goldschmidt, authority on genetics, and professor of zoölogy on the Berkeley campus of the University of California.

His book, *A Study of Spontaneous Mutation*, was published by the University of California Press. It contains data on thousands of fruit fly matings in a series of experiments which have been carried on continuously for the last ten years.

Dr. Goldschmidt speaks of spontaneous mutation as the most important phenomenon of genetics, because he says the theory of heredity, as well as that of evolution, is based completely upon it. He indicates that this work throws light on the causes of mutation in nature, about which little is known.

"The general trend of these data is to suggest that mutation is not a haphazard event in a so-called gene molecule," Dr. Goldschmidt says, "but a phenomenon of a determinate, orderly type which is caused by conditions within the chromosome."

#### Milk Company Profits Less Than 1/3c a Quart.

Profits of milk companies have been less than one-third of a cent a quart—.3 of a cent to be exact—according to an Indiana University Bureau of Business Research nationwide study of milk distribution costs.

The cost of raw milk delivered to the plant along with the wages and salaries of workers took nearly 82 cents of each sales dollar.

Expenditures for plant, delivery, and office supplies and services required 7.28 cents of each dollar of sales, while taxes, insurance and depreciation accounted for 5.96 cents of each dollar received by the milk distributors.

Bottles and other containers cost 3.22 cents for each dollar of product sold. Operating costs totaled 98.02 cents, leaving an operating profit of 1.98 cents for each dollar of sales.

The study, made for the Milk Industry Foundation, was based on reports direct to the bureau from 244 companies in major cities throughout the country with sales in excess of \$583,000,000 in 1944.

The Indiana University cost study was made following a national poll of consumer opinion by the Opinion Research organization which showed 43 per cent of the consumers think distributors make from 3 cents to 9 cents a quart profit.

The poll of consumer opinion also showed that only three out of every ten consumers know anything about Government subsidies which hold down retail prices.

**Press Clippings.**—Some news items from the daily press on matters related to medical practice follow:

#### Extract Found to Kill Tuberculosis Bacilli

Los Angeles, Sept. 14.—(AP.)—Dr. Anthony J. Salle, assistant professor of bacteriology at the University of California at Los Angeles, says he has discovered that a bacillus extract known as subtilin will kill tuberculosis bacilli.

"Subtilin is much like penicillin," said the bacteriologist, "but it goes further in this particular field. Penicillin is not deadly to the tuberculosis bacillus, but subtilin is. It is also fatal to other bacilli, including streptococcus, staphylococcus, pneumococcus and gonococcus."

Salle, who has been working on the subtilin project for seven months with a co-worker, research assistant Gregory Jann, said the substance is derived from a bacterium called bacillus subtilis, commonly known as "hay bacillus," which is found in the ground, in the air and on hay.

In Chicago, Dr. Maurice Fishbein, editor of the *Journal of the American Medical Association*, made this comment on Dr. Salle's announcement:

"There is little reason to be optimistic about the study at this time.

"Many new drugs have been found in the past to control the organisms of tuberculosis in the test tube, but when they were applied to the human body they did not prove effective. There is no reason why the search should not continue; yet there is little reason to be especially optimistic about this discovery at this time."—*San Francisco Call-Bulletin*, September 14.

#### My Day

Hyde Park, Sept. 6.— . . . Most people who have even moderate incomes prepare for the advent of a baby and lay the money aside. If there are no great complications, that does not cause a complete dislocation of the family budget. It has meant a great deal to many young wives of men in the service to be taken care of under the E.M.I.C. Plan, and I have had a number of them say rather wistfully that they wished such a plan could continue functioning in peacetime. . . .

It seems to me the Government might well guarantee that these two phases of the health of the Nation shall go forward unhampered and properly financed.

The Senate Health Bill, as proposed, puts much responsibility on the states. But it does leave supervision in the hands of the surgeon general, and I think the advisory committee gives the kind of safeguard which should make sure that there will be no hampering of either research or education in the future.

Federal assistance should be available for the handling of hospitals and clinics. This, of course, is essential, since many communities can meet the running expenses, but are unable to make the first capital investment for buildings and equipment.

On the whole, the Wagner-Murray-Dingell health bill seems to me to give us more hope than we have ever had for health in our communities throughout the Nation.—Eleanor Roosevelt in *San Francisco News*, September 7.

#### British Find New Chemical a Super DDT

Boston.—A super-DDT, a synthetic compound even deadlier to insects than the original DDT, has been discovered by British chemists. It is known by the convenience-name of Gammexane, and is sometimes referred to by the Apocalyptic number 666. Its exact chemical designation is the gamma isomer of benzene hexachloride.

Not closely related to DDT in its structural chemistry, the compound seems to be even more of a knockout so far as insects are concerned, a report by A. D. Little, Inc., states. By a curious coincidence, its history is like that of DDT in that its existence had been known for a long time, but its insecticidal properties had not been suspected until it was tried out relatively recently. Then it was discovered to be the deadliest weevil poison that the British firm's chemists had ever tested, and it would kill flies in half the concentration required in a DDT solution. It was also proven to be deadlier than DDT to *Aedes aegypti*, the mosquito that carries yellow fever.

It is not known whether Gammexane is as persistent as DDT under ordinary use.—*Science Service*.

#### Housewives Cautioned Against Improper Use of DDT in Home

Keep Poisonous Powder Away From Kitchen Supplies, Dr. Fishbein Advises; Says Large Doses Can Prove Harmful

Housewives who find use for DDT, the powerful new insecticide known to chemists as dichlorodiphenyltrichloro-

thane, are cautioned against placing the poisonous powder where it might be mixed with kitchen supplies.

"In large doses DDT is poisonous to human beings and to a good many animals," writer Editor Morris Fishbein, M.D., in the October issue of *Hygeia*, the health magazine of the American Medical Association. "When DDT is properly used, these poisonous effects are controlled; if it is improperly used, they may be harmful." Continuing, Dr. Fishbein said:

"Experiments made during the war show that DDT has a great variety of uses as an insecticide. It gets rid of mosquitoes, bedbugs, lice, fleas, moths and other insects.

"Since it can destroy fish, cattle or fowl if taken in large amounts into the body, its use should be limited so as to prevent the destruction of animals.

"DDT is best used as a spray, or as a powder, in the concentrations that have been found to be efficient for specific purposes.

"DDT is known to be efficient against the codling moth that attacks apples, the cherry fruit fly, the cabbage worm, the grape-berry moth, and the raspberry fruit worm.

"Against ants and termites DDT is toxic in relatively low concentrations. Ants exposed to a five per cent solution have difficulty in walking within a few minutes after coming in contact with it. After half an hour, most of them are unable to stand up; they die several hours later. Termites avoid DDT if it is in their neighborhood, but a great deal more needs to be known about ways to get termites into contact with DDT. When DDT is sprayed on house screens, dissolved, as it frequently is, in kerosene, it is effective in destroying flies and preventing their entrance into homes. It has been found useful against fleas on dogs and against roaches.

"DDT, when used to destroy insects, is mixed with other substances. Thus the user is confronted with the hazards not only of DDT but also of the substances with which it is mixed. Kerosene is inflammable; this carries a fire hazard. In the weak dilutions in which DDT is usually used—anywhere from one to three or five per cent—around the house as a spray or a powder for dusting, it is relatively safe. When used in immense quantities, the possibility of inhaling large amounts of DDT into the lungs brings another hazard. People who are professionally engaged in the work of insect extermination should probably use respirators for their own protection."

In reviewing DDT's development, Dr. Fishbein explained that the chemical had been known for almost 70 years. When the Germans passed up an opportunity to make use of it, Swiss scientists synthesized the product and found out its insecticidal value. As far back as 1938 it was used to get rid of a beetle which threatened Switzerland's potato crop.—*J.A.M.A.*, Sept. 13.

#### Newsprint Controls May Be Ended December 31

Washington, Sept. 13.—(AP.)—All government controls on newsprint will be abolished December 31, it appeared likely today, and paper allocations to United States publishers will be increased for the fourth quarter.

Relaxation of newsprint usage restrictions one full degree in the sliding scale formula of deductions beginning October 1, and revocation of Limitation Order 240 at the end of the year were recommended by the newspaper industry advisory committee at a two-day session with War Production Board officials, the agency announced. . . .—*Los Angeles Times*, September 14.

## LETTERS†

### Concerning California Board of Medical Examiners—Examination and Reciprocity Statistics:

September 21, 1945.

Frederick N. Scatena, M.D., Secretary  
California State Board of Medical Examiners  
1020 N Street, Room 536  
Sacramento 14, California.

Dear Doctor Scatena:

In CALIFORNIA AND WESTERN MEDICINE for June, 1945, on P. 315, was printed the address you gave at this

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

year's annual session of the California Medical Association.

In that report you gave statistics concerning the number of those who had taken written examinations and reciprocity-oral examinations. The figures were not given for the year 1945.

\* \* \*

I am writing to ask if you have statistics for the first six months of the current year.

Inquiries have come in asking for information concerning the number of physicians who have not had licenses in California, and who are applying for such either through written examinations or through reciprocity-oral examinations.

What information can you give us in regard thereto?

\* \* \*

Under the present interpretation of the Medical Practice Act for M.D. physicians and surgeons, how often is the State Board of Medical Examiners holding examinations?

Cordially yours,

GEORGE H. KRESS, M.D., *Editor*.

\* \* \*

(COPY)

STATE OF CALIFORNIA  
Department of  
PROFESSIONAL AND VOCATIONAL STANDARDS  
Board of Medical Examiners

Sacramento, California, September 26, 1945.

Yours of September 21st. Re: Statistics.

Dear Doctor Kress:

In view of the law which states that an examination must be afforded an applicant within six months of the filing date, the numbers of examinees so falling due will determine the number of oral examinations we will have each year.

Written examinations are usually conducted four times a year. A written examination is held at each regular meeting of the Board of which there are three, and a special written examination was held this year in San Francisco to accommodate those who, because of the accelerated medical course, were graduating at a time falling between our regular examinations. We enclose herewith a memo giving the number of applications for written examination and the number of applications for reciprocity filed between January 1 and July 1, 1945.

Our statistics are as follows:

Class A: Written.....	342
Class C: Reciprocity.....	382
Class D: Government Credentials.....	16
Class G: National Board.....	47
	<hr/> 787

Very truly yours,

(Signed) FREDERICK N. SCATENA, M.D.,  
*Secretary-Treasurer*.

#### Concerning Relative Amount of Energy in Climbing and Walking:

STANFORD UNIVERSITY  
Department of Physiology

Stanford University, California, Sept. 17, 1945.

Dear Mr. Kress:

In reply to your letter of Aug. 13 requesting information for Mr. Jerry Carpenter, State Chamber of Commerce regarding "the relative amount of energy required

by men and women in climbing stairs, as against traveling on level ground."

The most accurate work along this line that I have found is "Gaseous Exchange and Physiological Requirements for Level and Grade Walking," by H. M. Smith, Publication No. 309, Carnegie Institution of Washington, 1922. In this paper it is shown that the increase in energy expenditure in walking horizontally amounts to about 0.5 gram calories per kilogrammeter. Walking up a grade requires an expenditure of 7.5 gram calories per kilogrammeter. Stairs are usually built so that the tread (horizontal distance) and the riser (vertical distance) are definitely related, e.g., 2 risers plus one tread = 23". On the stairs in my house the riser = 16.5 cm. and the tread = 28.5 cm. A 50 kilo man climbing 10 such steps would expend energy as follows:

Horizontal progression,  $50 \times 10.0 \times 0.285 \times 0.5 = 71.25$  cm. cal.  
Vertical progression,  $50 \times 10.0 \times 0.165 \times 7.5 = 608.75$  gm. cal.

Therefore it requires nine times as much energy to climb the stairs as it would to progress the same horizontal distance.

I hope this information is adequate but will be glad to go into the subject at greater length if need be.

Yours sincerely,

J. PERCY BAUMBERGER,  
(*Prof. Physiol.*)

#### Concerning Generous Gift to Barlow Sanatorium by Los Angeles Elks:

THE BARLOW SANATORIUM ASSOCIATION

Incorporated under the Eleemosynary Laws of California

1301 Chavez Ravine Road

Founded by Dr. W. Jarvis Barlow

Los Angeles, California, October 2, 1945.

CALIFORNIA AND WESTERN MEDICINE

450 Sutter—Room 2004

San Francisco, California.

Sirs:

This is to announce that the Barlow Sanatorium of Los Angeles has just received a gift of \$12,000 from the B.P.O. Elks Lodge No. 99 of Los Angeles for the establishment of a library for research in tuberculosis.\* This fund is intended to finance the erection of a small building, the purchase of furniture and equipment, books and medical journal subscriptions. It is hoped to build up as complete a library as possible in the field of tuberculosis and diseases of the chest.

This library will be designed to serve the staff of the Sanatorium, the teaching of student nurses in tuberculosis, teaching of medical students from the University of Southern California in tuberculosis, post graduate courses for physicians in tuberculosis, an physicians or other persons in this area seriously interested in tuberculosis. The reading room of the library will be designed for use as a class room for staff meetings, committee meetings, lectures, etc.

It will be known as the Elks' Tuberculosis Library of the Barlow Sanatorium.

Sincerely,

The Barlow Sanatorium Association,  
HOWARD W. BOSWORTH, M.D.,  
*Medical Director*.

\* Cooperation of B.P.O. Elks Lodge No. 99 of Los Angeles made it possible for California Medical Association to obtain meeting room facilities for the annual session held this year on May 6-7, 1945.

The late W. Jarvis Barlow, M.D., founder of the Barlow Sanatorium also founded the Barlow Medical Library, later to become the Library of the Los Angeles County Medical Association.—Ed.

## TWENTY-FIVE YEARS AGO†

### EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVIII, No. 10, October, 1920

#### EXCERPTS FROM EDITORIAL NOTES

*Attention, Physicians, Voters!*—Are you interested in continuing the practice of scientific medicine in California? Do you believe scientific medicine has any contribution to make to California in her social, economic and health development? Do you recognize that being a physician ought to make you a better citizen? Do you know that the election on November 2, 1920, so far as it affects these points, will be determined by what YOU do? . . .

#### EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

*From an Article on "The Present Status of Anesthesiology and the Anesthetist," by Eleanor Seymour, M.D., Los Angeles.*—The administration of anesthetics is an art ancient and honorable, signalized as are few procedures by both divine sanction and usage, for in the second chapter of Genesis it is recorded that "the Lord caused a deep sleep to fall upon Adam and he slept, and He took one of his ribs and closed up the flesh instead thereof." It is cause for regret that there is no detailed account of the induction and maintenance of this first anesthetic but it is evident that the administration was considered of such importance as not to be entrusted even to the Angel Gabriel,—must less an angelic nurse,—and of Adam's safe and satisfactory recovery there is abundant record. . .

*From an Article on "Some Recollections and Ophthalmologic Observations from Service in the A.E.F. in France," by Vard H. Hulen, M.D., Berkeley, California.*—As only a few members of this section had service in the A.E.F., some observations based on my experiences "over there" may be of more interest to you than a scientific effort limited to fifteen minutes, and a discussion of my deductions may be of some practical use even now.

The goal of every medical man who early volunteered his services was naturally France, so that when directed in September, 1918, to join B. H. 104, then almost completely organized at Camp Dodge, Iowa, destined for overseas service, I was relieved from the suspense of having waited nearly six months for overseas orders. . .

*From an Article on "Californians on the Italian Front—Historical," by Thomas C. Myers, Major M. R. C., Los Angeles.*—Through the generous gift of \$100,000 by Mrs. Diebert of New Orleans a hospital unit was organized in the United States known as the Loyola Unit, afterwards accepted by the U. S. A. as Base Hospital No. 102. The selection and organization of the nursing corps were delegated to the Sisters of Charity who were peculiarly fitted for this duty by reason of their management of many hospitals and training schools throughout the United States. . .

*From an Article on "End Results of Radical and Conservative Pelvic Surgery," by Alice F. Maxwell, M.D.,*  
(Continued in Back Advertising Section, on Page 30)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members. Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco 8.

## BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. SCATENA, M. D.  
Secretary-Treasurer

### Board Proceedings

A regular meeting of the Board of Medical Examiners will be held at 1020 N St., Sacramento, from October 15 to 18th, 1945. Written examinations for all classes will be conducted and legal hearings will be conducted during the meeting.

### News

"Found guilty of three counts of practicing medicine without a license, Mrs. Pauline Vigil of 1823 N. Buena Vista St., today had filed notice of an appeal. The jury reached a verdict of guilty in a case tried before Police Judge Raymond L. Reid's court. Charges had been preferred by the State Board of Medical Examiners, under the Business and Professions Code." (*Hollywood Citizen-News*, August 14, 1945.)

"A Glendale physician was under arrest today charged with falsifying a birth certificate to enable the adoption of a 'black market baby' without the formality of going through state controlled adoption, according to Glendale police. He was Dr. Philip V. Abrams, 30, of 1601 Griffith Park boulevard, Glendale, who maintains an office in that city at 115 West Hayworth Avenue. . . ." (*Los Angeles Herald and Express*, August 9, 1945.) The records show that Dr. Abrams is under jurisdiction of the Board of Osteopathic Examiners.

"In Long Beach, California, a woman 'doctor' has been indicted for murder and police believe that through her arrest they have cleaned up 'one of the nation's largest abortion mills.' The woman has admitted that she performed from 30 to 35 abortions each week for the past two years—a total of more than 3,000. Her arrest followed the death of one of her 'patients,' the wife of a navy man. The woman spoke freely to police of her life-destroying work, and said that she had been engaged in the nefarious practice of performing abortions ever since she moved to California 18 years ago. . . ." (*Banning Live Wire*, July 12, 1945.)

"Dr. Samuel D. Collins, 42, chiropractor, accused of performing illegal operations which led to one death and another critical illness, today was free on \$7,500 bail and denied performing either operation. Trial has been set for Sept. 28. Collins was seized in front of Georgia Street Receiving Hospital after police reported he tried to push Crystal L. Hawkins, 23, from his automobile. At the hospital, Mrs. Hawkins was found to be suffering from the effects of an illegal operation. The chiropractor is also under suspicion in connection with the death of Margie F. Wilson, 20, also from an illegal operation, July 27." (*Pasadena Star-News*, August 7, 1945.)

"His 'love cure' prescription and subsequent beating of the woman patient who refused it today sent Dr. Wendell White, 35-year-old Glendale physician, to jail for 90 days of a 180-day term. Police Judge Charles Dwyer sus-

(Continued in Back Advertising Section, on Page 32)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the secretary of the board.